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Table 1. Demographic characteristics of the study

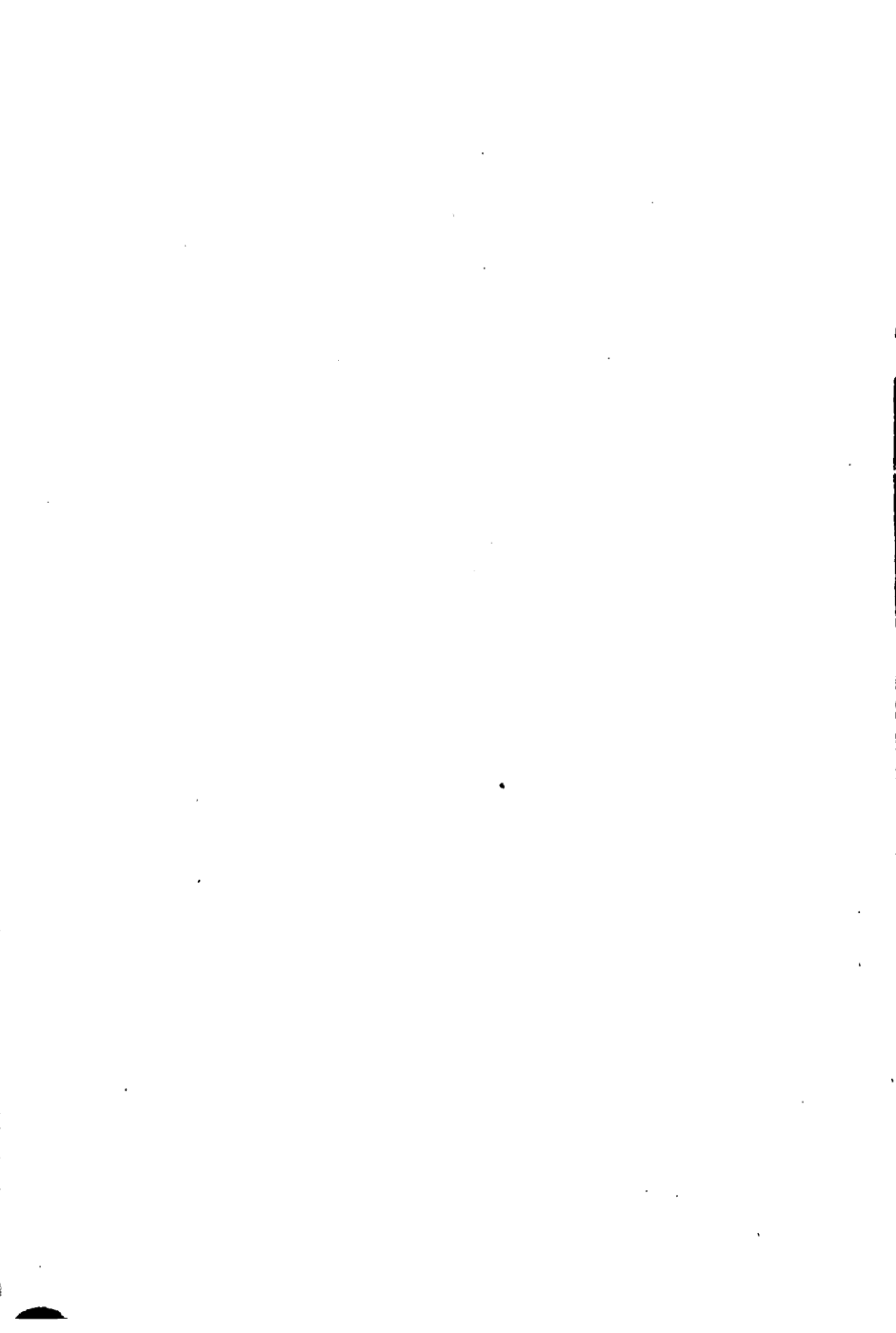
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1. Insurance (Richardson)

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STANDARDS OF HEALTH INSURANCE

BY

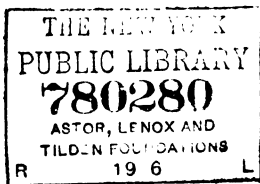
^{DC}
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**Executive Secretary Social Insurance Committee, American
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1915; President Casualty Actuarial and Sta-
tistical Society of America**



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PREFACE

THE time appears ripe for a comprehensive study in English of European experience with sickness insurance, but the little book offered to the readers does not pretend to meet this need. Its purpose is a very much more modest one.

The movement for sickness or health insurance in this country has been growing so rapidly within the last few months that there appears to be a demand for a brief and popular, though scientifically sound, discussion of the essential principles underlying it and the various provisions which go to make a successful health insurance scheme; and without many excursions into the domains of statistics of history, this book endeavors to cover this particular field.

The subject-matter has largely appeared in the *Journal of Political Economy* for March, April, and May, 1915, but in that form has reached a very limited circle only. Some new additional material was added that had to be omitted from the original articles because of considerations of limited space.

The articles appeared originally under the title of "Standards of Sickness Insurance," but within the last few months, largely due to the decision of the Social Insurance Committee of the American Association for Labor Legislation, the term "Health In-

surance" has obtained wider publicity, and it was decided to accept the new term in this study. There were largely three considerations which influenced the Social Insurance Committee in favor of the term "Health Insurance" rather than "Sickness":

First.—The term "Health Insurance" has been adopted and has been in use for some time by commercial insurance companies.

Second.—It seemed, in the opinion of the committee, to emphasize the preventive character of the measure.

Third.—It has the weight of British precedent behind it.

The last consideration may not be altogether a fortunate one, because, as will appear to the reader of these pages, the scheme suggested on the whole approaches the German system much more closely than the British one and the shortcomings in the workings of the British system have been frequently pointed out in this book. Health Insurance plans at present before the people of this country should not be judged too harshly by some experiences under the British precedent.

It is very difficult to find a purely logical argument for the selection of either term. There is no one guiding principle in designating various branches of insurance. In some branches the person, object, or condition insured, and again in others the hazard insured against, serve as a designating term. Thus we speak on one hand of workmen's insurance, or

PREFACE

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life insurance, or plate-glass insurance, or health insurance, where the term is based upon either the person (workman), or condition (health or life), or object (plate glass) insured, but we also speak on the other hand, of fire, burglary, accident insurance, etc. An arbitrary decision, therefore, seems justified.

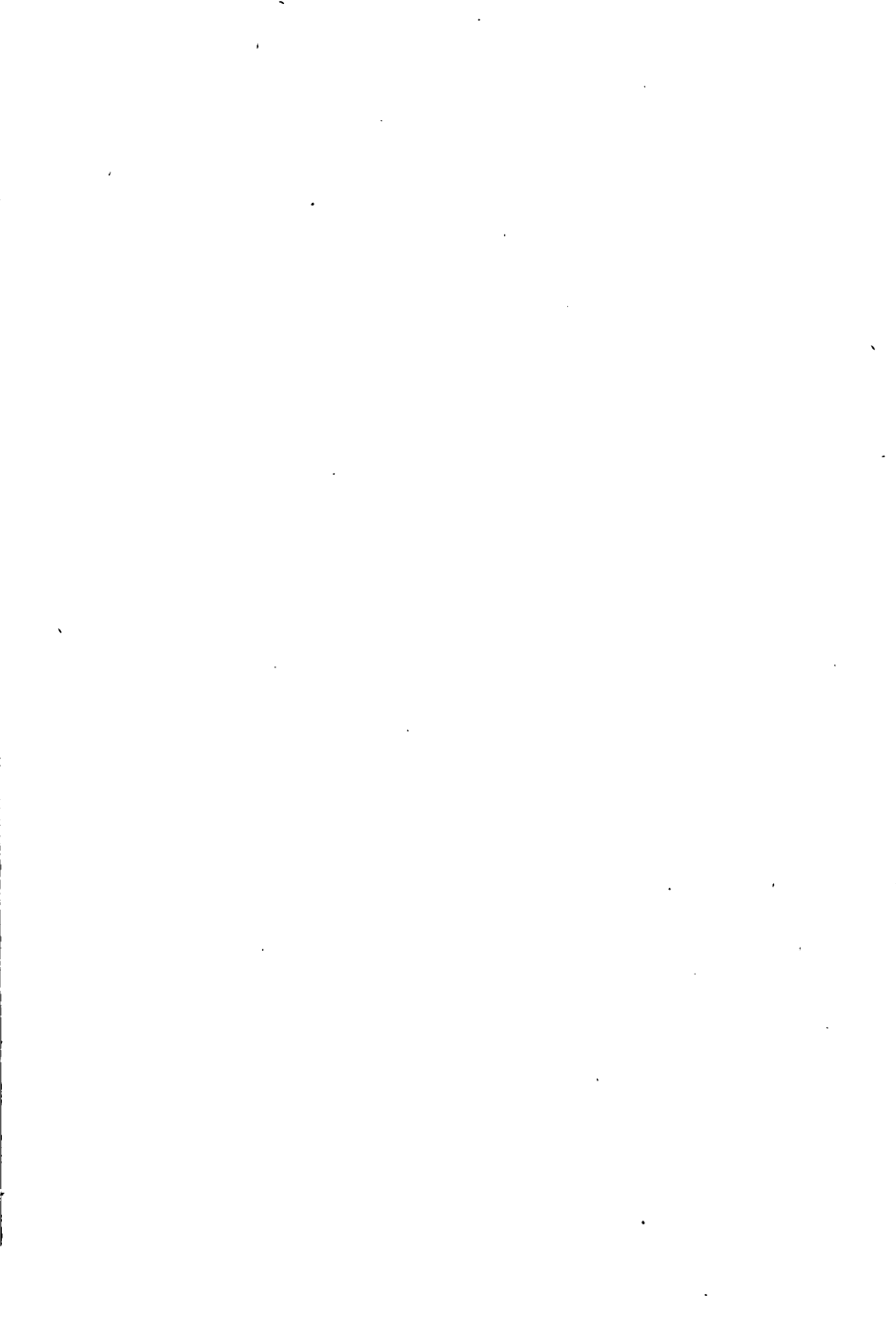
I am under great obligations to Prof. Joseph P. Chamberlain, of the Legislative Drafting Bureau of Columbia University, for his kindness in preparing the valuable chapter discussing the "Constitutionality of Health Insurance"; to Dr. Alexander Lambert, Chairman of the Social Insurance Committee of the American Medical Association, for his permission to use his report on "Organization of Medical Aid"; to the *Journal of Political Economy* for permission to reproduce articles which have appeared in that publication, and to Mr. Solon De Leon, of the American Association for Labor Legislation, for his careful reading of the proofs of the entire book.

June, 1916.

I. M. R.

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STANDARDS OF HEALTH INSURANCE

I

INTRODUCTORY

WITH the rapid conquest of public opinion over popular prejudices in matters of employers' liability, the United States stands committed to the policy of social insurance. Without exaggeration this is the most significant advance in the social policy of this country during the last two decades, and the speed of progress is a very noteworthy feature. Considering the enormous amount of legislative work required the progress made by the workmen's compensation movement since 1908 is amazing.

On May 30 of that year, the U. S. Congress, urged on by President Roosevelt, passed the first American compensation act, narrowly limited to a small minority of the employees of the Federal Government, and pathetically inadequate in its benefit provisions. Two years later, the first general state compensation act was adopted by the legislature of the State of New York, and soon was declared unconstitutional. The first state act to remain in force

went into effect in New Jersey on July 4, 1911. But on January 1, 1916, thirty-three states and territories had compensation acts in force. Of the remaining states a good many are in process of passing or preparing their acts; only in the solid South may a few states be found in which no movement toward abandoning employers' liability has been started. But the acts of Maryland, Kentucky, and West Virginia in the north, Louisiana in the south, and Oklahoma and Texas in the west are a significant indication that at least in this branch of labor legislation the "solid South" is solid no longer.

Undoubtedly a good many, perhaps most, of the acts are far from granting all that may be expected of a fair and just system of workmen's compensation. The radical changes already made in many of the acts, as, for instance, those of California, Connecticut, Massachusetts, Minnesota, Ohio, and Wisconsin, notwithstanding the very short experience with the original enactments, show that the whole matter of compensation is as yet in the formative stage. But the principle itself is practically accepted without further discussion. The shortcomings of the acts are easily explained by lack of familiarity, on the part of all social groups concerned, with the problems at issue. Surely in no other way can be explained the complacent acceptance by the ~~age~~ workers of such preposterously inadequate laws as, e.g., those of New Jersey, Colorado, or Pennsylvania.

The flood of literature on compensation has not

subsided, but has acquired a deeper character. Instead of agitation, there is inquiry; instead of popular articles, specialized technical studies. Already the formation of the Casualty Actuarial and Statistical Society of America has furnished a new important medium for the scientific study of statistical and insurance problems of compensation which were scarcely recognized three or four years ago.¹ With this issue practically settled, at least in principle, the attention of the progressive student in social legislation may be centered upon other correlated problems.

Already, the first steps have been taken toward creating a sentiment in favor of other branches of social insurance. The First American Conference on Social Insurance, held in Chicago in June, 1913; the establishment of a department of social insurance in the *Survey*; the preparations for the International Congress on Social Insurance in Washington (unfortunately abandoned because of the outbreak of the Great War); the creation of a Social Insurance Commission in California in 1915—all these are symptoms of the new movement. Health insurance was one of the main subjects of discussion before the meeting of the American Association for Labor Legislation in Washington in December, 1913, and again in December, 1915. Old-age pensions and insurance have been thoroughly discussed in official reports in Massa-

¹ See *Proceedings of the Casualty Actuarial and Statistical Society of America*, Vol. I, 1914-15; Vol. II, 1915-16.

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chusetts and Wisconsin; unemployment insurance was emphasized in the recent conferences of the American Association for Labor Legislation held in New York in March, 1914, and in Philadelphia in December, 1914. And scarcely any of the numerous unemployment commissions created during the winters of 1913 and 1914 failed to point at compulsory unemployment insurance as at least a partial remedy. How far mothers' pension laws technically constitute an extension of social insurance methods, is still a question calling forth heated discussion among students and advocates of social legislation in this country. But whatever the technical aspect of these laws, whatever even their social efficiency, it must be admitted that the adoption of acts of this character by twenty-odd states within the last two or three years is an important victory for the principle of "Soziale Fürsorge" or "Prévoyance Sociale" which underlies the entire social insurance movement.

It is impossible to prophesy with certainty which one of these branches of social insurance will be the next one to be taken up seriously by American legislatures. A good deal often depends upon sudden development of popular interest or social pressures; witness, for instance, the very wide interest displayed by organized labor and the Socialist party in the National Old Age Pension Bill introduced by the first Socialist Congressman Victor L. Berger, or the national excitement over the problem of unemployment in the winter of 1914, under

the influence of the picturesque efforts of the I.W.W. to invade the churches of New York City. But a normal development of the social-insurance principle would seem to demand that the next step be taken in the domain of health insurance.

Several reasons for this may be mentioned. Admittedly unemployment insurance presents many technical difficulties which even in Europe have delayed its development.

As yet the British experience of two or three years is the only fountain of information to be drawn upon. It is recognized by all students of unemployment insurance that its success absolutely depends upon a comprehensive network of public employment offices or labor exchanges, and it is urged by many that these be established and roughly organized before the more complicated problems of insurance are undertaken.

In the problem of old-age provision we are necessarily confronted by the antagonism (perhaps more seeming than real) between the principle of insurance and the principle of gratuitous governmental pensions, which will delay legislative action for some time, especially in view of the growing popularity of the pension principle among organized workers. No such serious difficulties prevent the development of health-insurance legislation.

The precedents, not only of continental Europe, but of Great Britain as well, offer a reasonable argument. There is a material basis for legislation in the existence of voluntary health-insurance organiza-

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tions of various types, and in the abuses discovered in connection with a certain type of commercial health insurance.

The practical application of the various compensation acts has brought to the surface the difficulty of differentiating between industrial accident and occupational disease, and between the latter and simple illness. The extension of the concept of industrial accident to all physical injuries (whether traumatic or pathologic) in several acts through legislative intent or judicial construction has pointed the way to general health insurance as the only way of meeting the problems arising from these difficulties of drawing the hard and fast line between accident and disease.

But perhaps the most important consideration is the quantitative one. Professional workers of relief agencies have long recognized that sickness represents the most frequent factor of individual destitution. The growth of the various health and life conservation movements, the concerted attack upon excessive child mortality, the alarming increase in diseases of middle age, and the mortality caused by them, the increased scientific activity in the study of industrial hygiene, all these various forms of scientific and social endeavor have brought to light not only the social waste caused by excessive and preventable illness but also the economic conditions which are responsible for them. Even minimum wage legislation and the statistical inquiries undertaken in connection

with it have added eloquent evidence of the need of some systematic social effort to protect the health of the wage-workers. The Social Insurance Committee of the American Association for Labor Legislation, organized in 1912, and perhaps the most influential organization in this field, was soon forced to shift from problems of compensation to those of health insurance. Many other committees and commissions, of relief societies, reform or industrial organizations, and of medical societies are studying the problem and preparing statistical material. Already bills have been introduced in the legislatures of New York, New Jersey, and Massachusetts and perhaps other states.

In short, health insurance is at present going through the same stage which accident compensation went through six or seven years ago. Perhaps a growth at similar speed may reasonably be hoped for, but the same or similar difficulties must be expected and, if possible, some of them should be prevented.

The bewildering variety of plans, systems, methods, and provisions of workmen's compensation found in the acts already passed may be defended on the ground that the country has been divided into so many experimental laboratories, in which the various products of ingenuity are being tried out, with the hope that the best plan will win in the end.

But after all it must not be forgotten that frequently it is a very painful process of human vivisection, and that many of these experiments are so

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plex concept, embodying numerous elements, such as compulsion, regulation, state subsidy, etc., etc., and since the arguments for or against health insurance (or any other measure of legislation) usually assume the form of advocacy or criticisms of various features of the measure proposed these will all necessarily be dealt with at some length in the discussion of individual standards.

It may be desirable, however, for the benefit of the busy reader, who cannot spare time to refer to other sources, to state here very briefly the essential considerations underlying the propaganda for health insurance in this country.

1. Illness is a "risk" or "hazard," i.e., represents a possible economic loss, which threatens every human being. Since "insurance is a provision made by a group of persons, each singly in danger of some loss, the incidence of which cannot be foreseen, that when such loss shall occur to any of them, it shall be distributed over the whole group"—insurance is evidently a method well adopted to mitigate the destructive effects of illness.

2. The wage-worker stands in greater need of health insurance, because: first, his economic status depends much more closely upon preservation of health; second, as a result of the unhygienic or harmful conditions of his life and work, he is very much more susceptible to ill health, than the members of the employing or all property-owning classes.

3. The advantages of health insurance are clearly demonstrated by the rapid extension of private health insurance of various forms, commercial as well as mutual.

4. The experience of Europe demonstrates that public concern in health insurance for the wage-working class is almost universal in all industrial countries. Practically every European country has some system of sickness or health insurance, and compulsory health insurance for the wage-workers has already been introduced in Germany, Austria, Hungary, Luxemburg, Norway, Great Britain, Servia, Russia, Roumania, and Holland. This should offer sufficient evidence that social health insurance is not a whim or fad, but a definite step in the development of labor and social legislation.

But against all these arguments the still popular plea is advanced that European conditions do not offer a fair measure of conditions in the United States, and that the solutions of economic problems which Europe has tried and found effective may not at all fit us, that this blind imitation of European remedies is highly dogmatic and demonstrates lack of familiarity with the ideals of American life. The proposals for compulsory health insurance of the wage-workers made in several states have been characterized as an "Un-American doctrine."⁴

⁴ "The Un-American Doctrine of State Compulsory Health Insurance," by T. L. Thompson, *Economic World*, March 4, 1916.

What then are the peculiar features of American life which would make this well-nigh universal movement of the industrial era utterly inapplicable here? The plea that compulsion is undemocratic, paternalistic, socialistic and what not, will be dealt with in its proper place, when the principle of compulsion is considered. But still more insistent, on one hand, is the claim that the guiding principle of American life requires a standard of wages sufficiently high to enable the wage-worker to meet all the necessary losses of illness, such as the cost of medical aid, out of his own earnings, and on the other, the assertion that American wages actually have that level. As Mr. Thompson puts it energetically,⁵ "the condition of employees in the United States does not warrant the enactment of such a plan."

The reasons for this attitude of this and similar writers, who represent commercial insurance interests, will be dealt with elsewhere. It is sufficient to point out at this juncture that the numerous studies of the economic conditions of the American wage-worker do not at all justify any such optimism. That wages in the United States as a rule have a higher monetary value than the corresponding wages in Europe may be readily admitted. But the numerous investigations made in connection with workmen's compensation, with minimum wage legislation, and so forth, have demonstrated a very fre-

⁵ See *Economic World*, March 4, 1916.

quent lack of correspondence between customary earnings and necessary minimum expense.

Professor Scott Nearing's conclusion that "half of the adult males working in the industrial sections of the United States receive less than \$600 per year, three-quarters are paid less than \$750 annually," and further "that half of the women fall below \$400 a year, while nearly nine-tenths receive less than \$750,"⁶ making no deduction for unemployment, have been given wide publicity. They have been charged with undue exaggeration. But waiving aside questions of statistical accuracy, the general conception concerning the customary level of American wages, and especially American annual earnings seems to be grossly misleading.

The country was recently flooded with statements emanating from an organization of Western railroad companies concerning the very high wages of engineers and trainmen. But the condition governing these exceptional trades must not be assumed without further inquiry to apply to American industry at large. Another serious student of wages arrived at the conclusion that in 1911, "at least half of the males aged sixteen or more, engaged in gainful occupations were earning less than \$626 a year."⁷ The wage data in the United States are very fragmentary; they are published by a multiplicity of permanent institutions,

⁶ Scott Nearing, *Wages in the United States*, p. 213.

⁷ Frank Hatch Streightoff, *The Distribution of Incomes in the United States*, p. 152.

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governmental and private, by special investigating bodies, and by private students. This is no place to go into an exhaustive study of the data, which has already been and is being done by other students. But that the earnings of the most unskilled and certain semi-skilled trades and occupations are not sufficient to provide for a decent family standard is now generally admitted by most persons familiar with actual conditions. At the hearing on a Health Insurance bill held before a legislative committee at Albany on March 14, 1916, Mr. B. B. Burritt, director of the New York Association for Improving the Condition of the Poor, testified that a family of 2 adults and 3 children needs at least \$56 a month for the barest necessities of life, which is more than the ordinary unskilled laborer can expect to earn, so that no margin is left for any emergency, including sickness.

The conclusions to which the writer came some years ago, may perhaps once more be stated here.^a

1. From two-thirds to three-fourths of all productive workers in the United States depend upon wages or small salaries for their existence.

2. From four-fifths to nine-tenths of the wage-workers receive wages which are insufficient to meet the cost of a normal standard of health and efficiency for a family, and about one-half receive very much less than that.

^a *Social Insurance*, pp. 43-44.

3. If a certain proportion of wage-workers' families succeed in attaining such a standard, it is made possible only by the presence of more than one worker in this family. This condition, however, can only be temporary in the history of any workingman's family.

4. An annual surplus in the workingman's budget is a very rare thing, and is very small.

5. The growth of savings-bank deposits in the United States is not sufficient evidence of the ability of the American workingman to make substantial savings. A large proportion of these savings belongs to other classes of population, and in so far as information is available, the average workingman's deposits are very small.

While these are all statements of static conditions, the investigation of the dynamics of the condition of the wage-working class leads to even more striking facts. It is but too often complacently assumed that the rise of American wages offers an almost automatic corrective to all economic problems of the wage-worker's existence. The point involved is of such tremendous importance for the basic motive of our entire social policy that a careful and painstaking inquiry was undertaken by the writer some two years ago.*

A comparison of wages and retail prices from 1890 to 1912 led to the following conclusions, at

* See "The Recent Trend of Real Wages," *American Economic Review*, Vol. IV, No. 4, Dec., 1914.

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present universally accepted by various shades of economic opinion:¹⁰

"In years of falling or even slowly rising prices, the American wage-worker was able to hold his own or to improve his condition to a slight extent. But when confronted with a rapidly rising price movement (accompanied as it was by a violent growth of profits) the American wage-worker, notwithstanding his strenuous effort to adjust wages to these new price conditions, notwithstanding all his strikes, boycotts, and riots, notwithstanding all this picturesque I.W.W.-ism, new unionism, and the modish sabotage, has been losing surely and not even slowly, so that the sum total of economic progress of this country for the last quarter of a century appears to be a loss of from 10 to 15 per cent in his earning power."

The growing demand for a constructive and a protective social policy toward the American wage-worker is therefore not a fad or a fancy. Whatever the reasons may have been for America lag-

¹⁰ See Professor John Gray, "Economics and the Law" (Address of the President), *Proceedings, 27th Annual Meeting of the American Economic Association*, 1914, p. 18; Professor Walter E. Clark, *The Cost of Living* (1915), pp. 107-108; W. E. Walling, "Who Gets America's Wealth," *Inter-collegiate Socialist*, Vol. IV, No. 2, Dec., 1915; *New Review*, Oct., 1915; D. H. L. Weld, *Marketing of Farm Products*; Professor E. D. Durand in his Presidential Address before the American Statistical Association, Dec., 1915; Professor W. Jett Lauck, in *Locomotive Engineers' Monthly Journal*, 1915; B. S. Warren and E. Sydenstriker, loc. cit., pp. 43-44.

ging behind Europe in matters of social legislation, and particularly that branch of it dealing with social insurance, these reasons are rapidly vanishing. If the harmful effects of the increasing cost of living will be counteracted, if organized society intends to undertake a serious campaign for prevention of destitution, if finally the movement for conservation of the health of the nation is to have any meaning at all, then health-insurance legislation becomes the burning issue of the hour.

II

THE PRINCIPLE OF COMPULSION

IN drawing references from European experience it will be sufficient to keep in mind the main types, and for this purpose three countries have been selected, representing the three distinct and perhaps most important types. These countries are Germany, Great Britain, and Denmark. Of course, this will not prevent more or less frequent references to the experience of many other European countries, in which social health insurance has been in existence for many years, such as Austria, Hungary, Russia, Switzerland, Norway, or others.

The systems of Germany and Great Britain are at present the two most important systems of health insurance, both being compulsory but with the important difference that Germany not only prescribes the obligation to insure, but also indicates the insurance-carrier, while the British system leaves the selection of the insurance-carrier to the free choice of the insured. Denmark has perhaps the best voluntary system of sickness insurance in Europe, and has been selected for this reason.

The three types represented by these three countries may be described as follows: (1) voluntary in-

insurance with state subsidies (Denmark); (2) compulsory insurance with a practically prescribed insurance-carrier (Germany); (3) compulsory insurance with freedom of choice of insurance-carrier (Great Britain).

The crucial question which demands an answer at the very outset is whether a voluntary or a compulsory system is contemplated. Almost all other provisions of the system depend upon this.

Voluntary insurance against sickness, as against accidents or other emergencies, exists as a spontaneous growth in this country as in almost all others. Both the commercial and the mutual, co-operative forms are well known. When, however, voluntary insurance is spoken of in connection with social-insurance problems, something more than platonic indorsement of existing provisions for voluntary insurance is meant. It is assumed that the state must take some definite steps to stimulate and encourage, or at least to control and protect, these spontaneous efforts. If compulsion is rejected, the choice is left between various degrees of assistance and guidance of the voluntary systems by governmental authority.

Accordingly, three systems of sickness insurance may be recognized in Europe, placed here in the logical order of development toward a comprehensive system rather than in strict chronological sequence: (1) voluntary insurance, regulated by state authority; (2) voluntary insurance with sub-

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stantial state subsidies in addition to regulation and control; and (3) compulsory insurance.

In comparing these three systems, the first noteworthy fact is the strong and increasing tendency toward compulsory insurance throughout Europe. Beginning with the German system established in 1884, no less than ten European countries have established systems of compulsory sickness insurance for all or most of their wage-workers:

Germany	1884
Austria	1888
Hungary	1891
Luxemburg	1901
Norway	1909
Servia	1910
Great Britain	1911
Russia	1912
Roumania	1912
Netherlands	1913

In addition many other countries, not popularly credited with compulsory systems of social insurance, nevertheless have such systems for certain groups of wage-workers (largely those employed in mining, railroading, and navigation) in virtue of special legislative enactments (Belgium, Italy, France, and Spain). Subsidized voluntary insurance against sickness may be said to exist in five countries only: Sweden, Denmark, Belgium, France, and Switzerland. The most important systems are those of Denmark

and Switzerland. That of the latter, however, is still in the making, though the act was passed in June, 1911, and the Danish presents the highest development of this form of social insurance at present. The purely platonic attitude of regulation persists in a very few European countries only. Great Britain, Switzerland, and Holland have abolished it within the last half-decade. Italy and Belgium (and perhaps France) may be included in this group.

The lesson of history is therefore strongly in favor of the compulsory principle in this branch of social insurance. Evidence to that effect has been strengthened within the last few years. After the organization of the first two or three compulsory systems in the early eighties, there seems to have been a twenty-year period of testing the experiment. As a result of this test the years 1909-13 have brought six new national compulsory sickness-insurance systems in Europe.

What considerations have brought about this victory of the compulsory principle?

1. The demonstrated inability to bring the neediest strata of the working class into the system by any measures short of compulsion. Under all voluntary systems the proportion of the insured in a definite labor group is in inverse ratio to its economic status. Ability and willingness to meet the cost of insurance presuppose the existence of some surplus in the budget and a sufficient cultural status for the appreciation of the advantages of the insurance principle.

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Both are least present in the lower strata of the wage-working class where disease is most frequent and the economic need caused by disease greatest. Experience has proved that only by compulsion can these be reached.

In Germany, i.e., the proportion of the population compulsory insured in 1911 was as follows:

	Population	Insured	Per cent
Males	82,000,000	10,800,000	82.2
Females	82,900,000	8,660,000	11.1
Total	<u>64,900,000</u>	<u>18,960,000</u>	<u>21.5</u>

It is also estimated that the further extension of the German compulsory insurance system through the act of 1911 has extended the system over an additional 5,000,000 by including farm laborers, domestic servants, and a few other groups, so that the proportion would be over 30 per cent.

In the United Kingdom the number insured exceeds 14,000,000 in a population of some 45,000,000, or a percentage of 31, the proportion of insured men being about 50 per cent and that of insured women about 20 per cent.

As against these imposing figures the proportion of insured workmen under even a liberally subsidized system is considerably smaller. In France the total number of adult persons insured in the "sociétés de secours mutuels" does not exceed 4,000,000 or 10 per cent. In Belgium, with a population of 7,500,000, the total membership of similar organizations

did not exceed half a million, or 6 per cent. In Italy the proportion is about 3 to 4 per cent, and in Spain less than 1 per cent.

A striking exception to this rule is presented by the experience of Denmark, where the voluntary system, carefully nurtured by government supervision and substantial subsidy, has succeeded in drawing into the voluntary system a very substantial proportion of the population of that little country, as the following figures for 1914 will show:

	Population	Insured	Per cent.
Males	1,338,000	401,800	30.0
Females	1,419,000	444,400	31.1
Totals	<u>2,757,000</u>	<u>848,200</u>	<u>30.5</u>

It must be pointed out, however, that half of the insured persons are women, most of them wives of insured men, while in Germany the insurance usually carries with it at least medical benefits for wife and family, so that in reality the percentage of insured families is still smaller in Denmark than in Germany.

But granting the splendid numerical development of subsidized insurance in Denmark, it does not follow that what is possible in such a small and compact community (and then after 25 years of development) could be easily realized in a vast country like ours.

2. Shifting the burden of insurance. A study of the social causes of disease establishes at least a par-

tial responsibility for illness on the part of industry and society. Justice would require that industry and society should share in the cost of health insurance. But besides this argument of abstract equity, there is the economic fact that for a large proportion of the wage-workers the earnings are such as to make the cost of insurance too heavy a burden. Both equity and necessity require that at least part of this burden be shared by other classes of society. The subsidized voluntary system recognizes this, and endeavors to relieve the burden by a state or local governmental subsidy. But only through a compulsory system does it become possible to shift part of the cost upon the employer and upon industry at large. The essential feature of compulsion is exercised upon the employer who is forced to meet part of the cost.

3. Standardization of the insurance service. Not only the quantitative, but also the qualitative, development of the insurance system must be considered. It is important, not only that all strata of workingmen be insured, but that the services rendered by the insurance institutions be effective and capable of meeting the problems which call for health insurance. Under a subsidized system an effort is usually made to accomplish this result by exacting certain conditions before the subsidy is granted. This method has reached its highest development under the Swiss law. But, at best, the requirements of a voluntary system cannot be far above the actual.

practice of the organizations existing at the time, or otherwise it is in danger of failing entirely. Thus, even in Denmark the quality of service is not always satisfactory, and is usually below that of the compulsory systems, as will appear from the detailed analysis of various provisions in the following pages. On the other hand, both Germany and Great Britain present and enforce definite minimum requirements, which are adjudged practical and necessary, while the very contribution from industry makes a higher minimum possible.

As against these advantages the system of compulsion is violently attacked on many counts. That such attacks should be made when the principle of compulsion is first suggested seems quite natural. In the very nature of things compulsion must be resented in a democratic country and needs to be justified. The objection to compulsion is therefore shrewdly utilized by all interests opposed to the basic principle of social insurance. We expect, therefore, private commercial insurance to oppose the principle of compulsion as utterly un-American, because it fears in social insurance a powerful competitor. We may expect representatives of employing capital to protest violently against this interference with the constitutional right of their employees, because they do not welcome the additional charge upon their own profits which the system invariably carries. We are not surprised even when fraternal insurance—in itself a valuable form of social insurance—lodges its

protest against compulsion because of its possible interference with the further development of the voluntary form of insurance. In all these and other cases we are dealing with definite interests rather than political ideas, and even if the latter are at all sincere they are inevitably influenced by the former. But as a matter of fact, antagonism to compulsion is found to some extent even among the wage-workers who are the chief beneficiaries of the plan. The arguments against compulsion must therefore be earnestly reckoned with.

What creates antagonism to compulsory insurance is the implied restriction of individual liberty. "I am going to be my own judge whether I am going to be insured against sickness or anything else, and if at all where and when and under what terms" many an American workman argues. "It is nobody's business but my own."

A spokesman for commercial insurance interests puts the same argument into more eloquent English. "If any citizen can by law be compelled to carry health insurance and pay therefor a part of his earnings, he can be compelled under the same principle of legislation to do anything else and pay the cost out of his hard earnings, if somebody else thinks it will be beneficial to him. Such a doctrine is absolutely destructive of a man's rights to do or not to do whatever his judgment may dictate as to matters that solely affect him personally. It is the exercise of

absolute and arbitrary governmental power over the individual.”¹

Of course the power is denied by this and many other writers on constitutional grounds. It is not the intention of the writer, who claims no standing as an authority in Constitutional law, to argue the question of constitutionality at this place. For this legal aspect of the question the reader is referred to the appendix, where an authoritative statement by an expert will be found. But it is sufficient at this time to point out that, in colloquial English, “You can lead a horse to water, but you cannot make him drink.” All the compulsion that is exercised over the wage-worker in the final analysis resolves itself into a money charge—somewhat akin to a tax. The benefits of the health insurance system will not be pressed upon him by force, and the power of the state to impose taxes is fairly well admitted. But is there really an entirely new principle of governmental authority involved? The principle of compulsory education, or compulsory vaccination, after all represents a much more substantial interference with personal liberty for considerations imposed upon the individual from the outside. Nor is the principle of compulsory insurance at all new and lacking in precedents in this country. In a number of states, as, for instance New York, Ohio, Washington, and several others, compulsory insurance of accident com-

¹ T. L. Thompson, *The Economic World*, March 4, 1916, p. 315.

pensation is forced upon the employer, and that only partly for his own good, and partly for the good of his employees. The compulsion to insure (and, in both Washington and Ohio, to insure with a certain insurance-carrier) is independent of, and additional to, the legal obligation to pay compensation.

Can the claim be made that the benefit of insurance is limited to the insured person himself, and therefore the compulsion is entirely gratuitous and paternalistic? Is it really "nobody's business but his own"? In the majority of cases the interest of the family is directly involved, since their economic status is entirely dependent upon his earnings. And in all cases without exception the social organism as a whole has a vital concern, for in absence of some organized protection every sick workman may become a charge upon the community both for his care and support.

The claim that this legislation is applicable only to a despotic form of government seems to be readily disposed of by the British act of 1911. And the passionate criticism of this legislation because it has been "imported from Europe," seems rather extravagant in view of the general acceptance of workman's compensation, which less than 10 years ago was decried with equal vehemence as thoroughly contrary to American traditions.

III

EXTENT OF HEALTH INSURANCE

HAVING determined upon a definite system of health insurance, to whom shall we make it applicable?

Under a compulsory system, this problem is somewhat more complex than if the system is voluntary. If the system is one of platonic regulation only, very few restrictions are necessary. When a substantial public subsidy is granted, it must be justified by the economic status of the beneficiaries, for it does not appear desirable to dissipate public funds, obtained from general taxation, in subsidizing the rich or even well-to-do.

In Denmark, membership in the subsidized societies, with full rights as to subsidy, is permitted to "wage-workers, artisans, home workers, and employees and other persons in similar economic conditions," while individual cases may be decided on their merits.

On the other hand, the comprehensive Swiss act of 1911, which establishes subsidized voluntary health insurance, contains no limitations as to membership, the assumption probably being that the subsidy is too small to tempt many individuals of the higher social groups who are not in need of such insurance.

As a purely abstract proposition, every form of

social insurance should be extended to all the classes which are in need of it, which would roughly fit in with the Danish formula "wage-workers and other persons in similar economic conditions."

But under all compulsory systems numerous limitations are often found and some of these limitations may, for reasons of practical administration, be quite inevitable, for compulsion requires a certain administrative machinery, which like all other machinery, can work successfully only under certain favorable conditions. It is generally admitted that insurance compulsion cannot successfully be exercised directly over the independently employed individual unless possibly a comprehensive passport system is introduced: that, on the other hand, compulsion and the necessary financial operations can be readily applied to the employer and, through him, to the wage-worker himself. For these reasons compulsory social insurance seldom if ever endeavors to extend beyond the employed class, wage-workers and salaried employees.

This limitation may, therefore, be described as an inevitable one, arising out of the very system of compulsory insurance. Other limitations, however, are less obvious, and must be explained by different social motives.

The original German act of 1883 was somewhat limited, applying to persons employed in mines, salt works, metallurgical establishments, quarries, pits, factories, railroads, and river steamships, on wharves

and in building operations, in mechanical trades and all other manufacturing establishments. It was gradually extended by numerous amendments to new industrial groups.

The act of 1892 included persons employed in commercial establishments, certain groups of clerical employees, those in the post-office and telegraph service, etc.

Roughly, the act of 1903, in force until the recent revision of the whole insurance code in 1911, included practically all industry, building, mines, quarries, transportation, commerce, and certain office employees. The act of 1911 broadened the application of the law so that practically all employees are included. The large groups brought under the law for the first time are the agricultural laborers, domestic servants, and home workers, about 5,000,000 in all.

In Austria the sickness-insurance act covers practically all manufacturing, building and construction, land and water transportation, and practically all commercial establishments, but not domestic service or agriculture or domestic industries. Similarly the Hungarian system, according to the amended act of 1907, includes almost all important wage groups with the exception of domestic service and agriculture.

It is significant that the more recent laws are more comprehensive from the very beginning. The Norwegian act of 1909 includes all industries and groups of wage-workers and salaried employees of certain

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wage levels, not excepting either domestic service or agricultural wage labor.

The British act, adopted many years later, from the first endeavored to be practically universal in its application. It covers all employed persons, with a few exceptions of minor importance, explained by special considerations, such as previous existence of similar provisions.

The lesson of European experience, therefore, is decidedly for a broad general act, rather than one limited in its application. It will probably be argued that it would be better to begin on a small scale, as Germany has done. But it must not be forgotten that we are entering the field thirty years later, and in face of a wealth of experience, while Germany was forced to undertake experimental work in an untried direction. Of course specific exceptions may be necessary, often depending upon local conditions. But the basic rule, or at least the ideal, should be general application.

The large groups, concerning which a definite decision must be arrived at in the very beginning, are four or five: (1) agricultural laborers, (2) domestic servants, (3) home workers, (4) casual and irregular employees, (5) government employees. Undoubtedly in the case of each one of these groups special conditions exist which may require special consideration in the act, or in the detailed regulations which must be left to some administrative body. Detailed discussion of all these specific conditions is impossible in a

brief outline of standards, such as is here intended, but the main points involved may be indicated here.

The history of compensation legislation in this country has already demonstrated that there is a well-proved tendency to except many of these groups. The argument is often lack of necessity for inclusion upon the plea either that the occupations are non-hazardous, or that the wage contract usually presupposes reasonable care during disability. That is frequently stated to be the case with the agricultural laborers and domestic servants. In many cases there may be a basis for this contention; but it cannot be universally true. Neither farmers nor housewives will support for an indefinite time disabled employees or widows and orphans of those fatally injured, and the peculiar conditions of the implied wage contract (in so far as they are not exaggerated) may at best demand only a modification and not an abolition of the compensation principles. Nor are the broad statements as to the lack of hazard at all based upon actual facts. The truth of the matter is that the exclusion of farmhands or domestic servants is due to the entirely different reason of expediency—to inability or unwillingness to force the additional charge upon farmers or householders.

The reasons for excepting these two groups from the benefits of a health-insurance scheme are even weaker than in case of compensation, for the arguments in favor of the system are not at all based upon any specific occupational hazard. Only on a ground

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of political expediency—the numerical and political strength of the farmers, the objection of the housewife to stamp-licking—can their exception be justified. Such compromises may temporarily be necessary, but it is better to be aware of the nature of such exceptions. The theoretical standards must include both.

Still stronger is the argument in favor of inclusion of the home workers and casual employees. Both of these groups are probably at the very bottom of the economic ladder. The economic and hygienic effects of illness among them are extremely serious. The cost of the insurance to the employer cannot be considered an excessive charge. But the exclusion of these two groups is often justified on entirely different grounds, namely by administrative considerations. When the conditions of the wage contract are temporary or involved and indefinite it is not always a simple matter to provide for the necessary administrative machinery to keep these two groups insured and enforce the employers' contribution. But the experience of Great Britain has demonstrated that it is not impossible to devise administrative methods to realize the insurance of these groups. The details are perhaps too complicated to go into at any great length here. Moreover, they do not constitute an essential aspect of the general standards. Difference in conditions may call for different provisions in this country. It may seem better not to embody such administrative details in the act, and the administra-

tive machinery created for the system may be trusted to possess enough inventive spirit to adopt European methods or devise new ones. But it is important to insist that the classes in question should not be excluded.

The situation is somewhat different in regard to government employees. The only reason for excluding them may be the permanency of their employment contract and, in addition, the provisions for disability already existing and often more liberal than those that a universal health-insurance system can offer. These conditions, however, seldom apply to the industrial employees of the government. No exception of government employees as such appears necessary, though the system established may contain a general proviso for distinct treatment of all groups already satisfactorily provided for in a different way.

Some opposition to the extension of a compulsory system to clerical employees may be expected because of similar considerations. It is argued that it is quite customary for employers of clerical labor, especially those employing large numbers, to continue the full salary during illness, and that systematic provision of sick benefits is therefore unnecessary, or even harmful because it would reduce the remuneration during illness to two-thirds, and in addition exact contributions from the employees. This argument was very popular in Great Britain when the National Insurance system was first introduced.

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But several important considerations are disregarded in this argument.

1. The practice is far from being universal. Deductions from salaries are not at all uncommon, even in case of large employers. And more frequently the salary is paid only in "worthy" cases, the decision resting entirely with the employer.

2. The full salary is seldom paid for any length of time (as for instance over one month) in the case of the less important employees.

3. Even if the salary is continued, no special allowance is made for medical aid, nor is there any care taken to provide such aid promptly.

4. There is nothing in any insurance plan to prohibit the employer from supplementing the allowance from the health insurance fund so as to bring it to a full amount of wages.

5. Health insurance only permits the employer to deduct the employee's contribution from his wages, but does not require him to do so.

It should be evident that a legally established contractual obligation is preferable to an allowance which is made voluntarily and may be withdrawn at any time at the will of the giver.

Only a few words need be added in regard to other limitations upon the extent of application of a health-insurance system.

Several American compensation laws contain exceptions based upon the number of persons employed by the individual employer. There is no justification

for these limitations which sacrifice the interests of the workman to the misguided social ideal of protecting petty industry—an ideal perhaps more hopeless in this country than any other. And there is still less reason for such exceptions in health insurance. As far as industrial hazard is concerned, it is probably true on the whole that there is less hazard in small establishments, which usually means establishments with little utilization of mechanical power. But as far as health hazards are concerned, the exact opposite is true—that the smaller the establishment the worse are the sanitary and hygienic conditions, the more danger is there to the health of the worker.

Age limits have been suggested, on the plea that minors, who while employed are not necessarily fully self-supporting, might be excepted; in Great Britain, persons who reach the pension age are also excepted. No good reasons for any such exceptions present themselves in this country—the fact of employment is of decisive influence. All restrictions would have the additional drawback of causing false statements, whether the influence might be toward or away from insurance.

More important is the restriction as to the size of the annual income which is found in most compulsory acts. In the case of the wage-workers employed in manual labor, such restrictions seem hardly necessary. The margins within which wages fluctuate are after all limited. They seldom rise to a level where health insurance would be altogether unnecessary,

and still more rarely do they remain on such a high level for a long time. Unemployment frequently reduces even the unusually high weekly wage to the basis of modest annual earnings; on the whole the weekly wage of the manual worker does not of itself offer any accurate basis of judgment as to the economic status, unless accompanied by reliable data as to the customary extent of unemployment; and the exact determination of the actual annual earnings is too complicated a statistical problem to serve as a basis for determining the insurance status of each worker.

But the situation is somewhat different in regard to salaried employees, who are included in a health-insurance system. The meaning of the term is not a rigid one. While a majority are wage-workers in everything except the technical nature of their work and the lesser frequency of payment periods, the class includes a small proportion of persons of very high incomes, to whom neither compulsion nor subsidy from employer or state would appear necessary.

Unemployment among salaried employees is comparatively slight. The size of the monthly salary check offers a reasonably accurate standard for determining the annual earnings. Some maximum limitation, therefore, appears useful. In Germany this has been placed at 2,500 marks, in Great Britain at £160. In this country, a limitation of about \$1,200 or \$1,500 a year would probably reach the same economic level.

Of course such a restriction establishes only the

limits within which organized and subsidized health insurance is an absolute social necessity. Even beyond it may prove to be very useful. In Europe, at last, a strong "Mittelstandbewegung" (middle-class movement) has developed which endeavors to gain for the lower strata of the middle class some of the advantages which social insurance has conferred upon the wage-worker. But in this country any effort to extend this legislation into higher groups would be premature and objectionable. For tactical reasons, if for no other, some reasonable limitations, on the lines indicated, are necessary. Opposition to social health insurance from the insurance companies and also from the medical profession would be stimulated by such extension into the middle class.

VOLUNTARY INSURANCE

It is necessary to remember that whatever advantage the voluntary insurance method possesses need not be lost in a compulsory system. It is very easy to tack a voluntary system on to the compulsory one. Both Germany and Great Britain have done so.

At least four distinct social groups may be mentioned, to whom the advantages of voluntary insurance may be offered.

First, there are the persons who carry insurance for some time under the compulsory law, and who, because of an improvement in their economic status, rise out of the compulsory class. It is very desirable

that they be permitted to preserve their membership, because their relief from compulsion may not be permanent, and because, having become used to this institution, they may consider complete retirement from it a hardship. The argument can be justly made by them that, having paid premiums while young and healthy, they are not fairly treated if required to abandon insurance at an advanced age. Under this group may be mentioned female employees, who cease being wage-workers through marriage. A system which would not permit them to remain insured would appear discriminating against the majority of female employees.

Secondly, there is a group consisting of members of a family working within their family, without any definite remuneration. As an illustration, the great class of farmhands working upon the family's farm may be mentioned. When they constitute an integral part of the family economy, no wages are paid, and in sickness they presumably will not be deprived of means of support. Yet the economic loss caused by sickness is not diminished merely, but transferred from the individual to the family unit. The advantages of insurance are evident, but before a general compulsory system for this class may be advocated, the privilege of voluntary insurance may be extended to include it.

Thirdly, there are all those wage-earners, or employees, who for some reason are not included under the compulsory system. If the reason for such ex-

ception is administrative rather than economic, it is evidently fair to permit them at least to come under the system voluntarily.

Finally, if the whole theory upon which compulsory health insurance is based is at all correct, then the same economic arguments may be applicable even beyond the groups of wage-workers and salaried employees, to those whose economic status is but little better. We have in mind the small independent producer or shopkeeper, who often is forced to remain independent because he is unable to obtain remunerative employment, either in industry or in commerce. As illustrations of this group may be named cobblers, tailors, bicycle-repairers, etc. Even the employment of one or two helpers is not always evidence that these employers earn more, and therefore need health insurance less, than expert mechanics. The admission of such individuals into the health-insurance system causes no difficulties for the latter, and may be a great advantage. Of course, in the case of all these voluntary groups, there is no contribution from the employer, either because of the absence of one, or because of the evident difficulty of such contribution in case of voluntary insurance. But the advantages of voluntary insurance are found in the economical management and careful state supervision of the insurance-carriers, and perhaps also in the government subsidy in which those voluntarily insured may be permitted to share. The question of such subsidy will be discussed in a subsequent chapter.

In any case, the existence of such advantages may require a limitation even to the voluntary insurance, and a convenient limitation may be found in the amount of annual income. Under the present level of prices, an annual income of \$1,500 may present a convenient dividing line, above which we find families able to solve the problem without any government compulsion or subsidy. Yet no dogmatic importance need be attached to this line of division. It will be necessary in the beginning, because the need of social insurance must still be argued from the economic necessities of the wage-workers; but in Europe at present this demand for the extension of social-insurance methods to the middle class is very great, and in many instances has led to legislation.

IV

THE SCOPE OF HEALTH INSURANCE

THE term "health insurance" may permit of several interpretations. The various branches of social insurance gradually merge into one another. As it is often difficult to draw the exact line of demarcation between disease and industrial injury, health insurance often merges into accident insurance. Even disability consequent upon old age is not always easily distinguished from sickness, and between these two lies the entire field of permanent invalidity. As a matter of fact, the artificial lines of division between the different branches of social insurance established in different countries do not often coincide. When the structure of social insurance is complete, these lines of demarcation are perhaps of secondary importance. Their effect is felt primarily in the different incidence of cost, which is far less important than the existence of the provision. When social insurance is only in the making, however, these exact circumscriptions of the field to be covered by every new plan proposed often determine the time when a certain group of cases of destitution is to receive the necessary relief. It is imperative, therefore, that the exact limitations of the phrase "health insurance" be carefully defined.

DISEASE AND ACCIDENT

Under this caption two problems present themselves, that of industrial and that of non-industrial accidents. The great publicity given to the question of workmen's compensation during the last few years has thrown the question of non-industrial accidents into obscurity.

Accidents may be defined as traumatic diseases (diseases or conditions brought about by external violence). Wage-workers, like other people, are subject to all these accidents of everyday life which are so frequent, particularly in this country. Perhaps few writers on the subject appreciate the importance of the non-industrial accidents. Out of 538,808 cases treated by the famous Leipzig local sick fund in 1887-1905, 62,295, or 11.5 per cent, were cases of non-industrial accidents, while the number of industrial accidents was only 42,893, or 8 per cent.

American statistics are extremely scant and fragmentary even in regard to industrial accidents, though efforts to gather them systematically gradually extend throughout compensation states. But in regard to the frequency of non-industrial accidents scarcely any definite information exists. It is known in a general way that all kinds of accidental injuries are more frequent in the United States than perhaps anywhere else throughout the civilized world, but to endeavor to obtain at present a definite measure of industrial and non-industrial accidents would be like

calculating the proportion between two unknown quantities. A few suggestive data may be quoted. According to Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Co.,¹ the experience among the 12 or 13 million policyholders of that company (which is preferable to general mortality statistics for our purposes because it covers primarily the industrial class, with its women and children) shows that deaths from "external causes" (largely accidents) constituted in 1911-1914 7.87 per cent of all deaths, or 94.4 per 100,000.

Even though recent years, under the influence of various "safety first" campaigns, show an improvement, from 95.6 per 100,000 in 1911 to 85.9 in 1914, the rate of accidental deaths is very much higher than, for instance, in England. Thus for "white male lives" age group 25-34, the ratio in the United States (Metropolitan experience) was 154.8² and for England and Wales only 61.9 per 100,000. Some part of this difference may be due to industrial causes, but hardly all of it can thus be explained. Such data as are becoming available seem to argue against a very great difference in the industrial hazards of the United States and Europe. It is at least a plausible hypothesis that, comparatively speaking,

¹ "Mortality from External Causes Among Industrial Policyholders of the Metropolitan Life Insurance Co., 1911-1914." *Proceedings of the Casualty Actuarial and Statistical Society of America*, Vol. II, No. 5, 1916.

² Louis I. Dublin, loc. cit.

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American life is more dangerous than American industry.

Some corroboration of this hypothesis may be found in the variations of this ratio according to age groups.

The number of deaths from accidental causes per 100,000 for white male persons in 1911-1914, according to the Metropolitan Company's experience was as follows:

Age group	Death rate per 100,000
Under 5	105.4
5-9	69.3
10-14	64.4
15-19	96.3
20-24	128.6
25-34	154.8
34-44	209.5
45-54	267.6
55-64	344.2
65-74	443.1
74 and over	605.7
<hr/> All ages	<hr/> 145.1'

The substantial death rates from these causes even for non-industrial ages are especially noteworthy.

Fatal cases, however, present only a very small proportion of non-industrial as well as industrial accidents (of the latter less than 1 per cent).³

³ See I. M. Rubinow, *Standard Accident Table* (1915), p. 38.

The largest insurance company writing personal accident insurance reports the payment in one year of 15,719 claims of which only 5,746 or 36.5 per cent were due to occupational causes. It is true that among the persons carrying this form of accident insurance non-industrial classes predominate; nevertheless the distribution of claims according to causes is at least suggestive.⁴

	No. of claims	Per cent	Payments
Autos and vehicles	1,303	8.3	\$361,437
Bicycles and motorcycles ..	240	1.5	21,880
Horses and vehicles	878	5.6	107,471
Other modes of traveling ..	1,247	7.9	273,041
Accidents at home	2,216	14.2	169,932
Sports and recreation	1,642	10.4	152,109
Accidents to pedestrians ...	1,877	11.9	141,915
Elevators	37	.2	16,693
Animal bites	92	.6	3,176
Miscellaneous	441	2.8	120,620
Total, non-occupational ...	9,973	63.4	1,368,274
Occupational	5,746	36.6	344,772
Total	15,719	100.0	1,713,046

It is evident that the compensation movement alone cannot solve the entire problem of accidental injuries.

It is the uniform practice, therefore, in prac-

⁴ *Travelers Insurance Co. Agents' Record*, Vol. X, No. 2, Jan. 29, 1912.

tically all health-insurance systems, to treat cases of non-industrial accidents exactly in the way in which cases of sickness are treated. The only notable exception is the new law of Switzerland, which has brought into existence a special system of insurance against non-industrial accidents. Under this system more substantial benefits are given than otherwise would be due, but the necessity of further complicating the structure of social insurance seems to be a serious objection. Of course non-industrial accidents often result in permanent disability which the health-insurance system usually does not take cognizance of, but it seems preferable to treat such cases exactly as other cases of invalidity are treated.

Somewhat more complicated is the question of industrial accidents. The treatment of such cases largely depends upon whether or not accident compensation exists at the time of the establishment of the health-insurance system.

In Europe health-insurance systems have been established in a few cases before accident compensation. It is quite certain, however, that in this country health insurance has no chance at all in any state before an accident-compensation law has been passed. Of course, if no accident-compensation law exists, the problem of industrial accidents does not seem to differ from that of non-industrial accidents except for one feature: there is the opportunity in many cases to collect more or less substantial damages from the employer. Even in case of non-indus-

trial accidents, a similar opportunity often presents itself as against the responsible person, since the law of "public" liability is in practice very much more stringent than that of employers' liability.

It is not the intention of the health-insurance law to create a condition of over-insurance, where the benefits may be larger than the loss, but, on the other hand, verdicts in liability suits are not collected without great loss of time, and immediate aid may be necessary. The situation may require special administrative provisions, not only in the case of non-industrial accidents, or industrial accidents where no compensation laws exist, but even in the presence of a compensation law, the application of which in most cases is subject to many narrow limitations. In other words, if in New York, for instance, an employee is injured, but for some reason finds himself outside of the protection of the compensation act, the health-insurance system should be made applicable. Where, however, the compensation law does apply, it is not and should not be the intention that double indemnity be paid. The simplest way to avoid the payment of such double indemnity would be through an automatic rule, by which a case comes under the provision of either one or the other of the two insurance organizations. In practice, however, the line of division is not so well defined. In all the three countries whose systems are analyzed for the purpose of deriving a set of standards, the sickness-

insurance carriers are required to carry part of the cost of accident compensation.

Germany has found it expedient to place the handling and compensation of all industrial accidents for the first 13 weeks of disability upon its health-insurance funds. Accordingly, industrial accidents for the first 13 weeks are, with a few minor exceptions, treated like all other cases of sickness. Similar treatment is given to industrial accidents in most other countries with compulsory sickness insurance, though the period of disability, the cost of which is imposed upon sickness-insurance funds, varies.

In Russia the same period of 13 weeks has been established by the new insurance act of 1912, much against the protest of the labor party in the Duma. In Hungary the limit is placed at 10 weeks, and in Austria it is placed at 4 weeks. The shortest period, of 2 weeks only, is found in Roumania.

The argument which may be made in favor of such arrangements is that the health-insurance carrier has the necessary machinery for the handling of such cases. Since the vast majority of all cases of industrial accident result in complete recovery before the expiration of 13 weeks (probably 94 per cent), the compensation-insurance machinery is relieved of the largest share of the work. A complete organization of a duplicate set of officers for handling the medical care and distribution of weekly benefits undoubtedly contains a serious element of waste.

Where accident compensation has come subsequently to health insurance, the uselessness of such duplication has been apparent. But, on the other hand, the grave objection may be raised that such an arrangement, in a thinly disguised form, forces back upon the wage-workers part of the cost of the accident compensation which is admitted by the very theory of compensation to be a proper charge upon industry. In Germany, the defense against this charge is found in the employers' contribution to the cost of health insurance. Even this defense, however, is absent in the case of Denmark, where the accident-compensation act does not come into play until after 13 weeks of disability, and all these cases are handled by the sick benefit funds, though the employer does not contribute anything to their support, and though insurance in these funds is voluntary and therefore not universal.

Great Britain has not followed this rather objectionable method, perhaps for the reason that in that country compensation had existed for fifteen years before the health-insurance law went into effect. The British law has, however, a waiting period of one week, unless the injury has lasted over two weeks. In such cases, the health-insurance system takes care of the injured. Moreover, the accident-insurance benefits being stated in percentage of wages, and the sickness benefits being specific (of which more later), cases may arise when the sickness benefits are higher than the accident benefits, in which cases the differ-

ence is paid to the injured from the health-insurance fund.

Altogether, it is evident that the entire charge placed upon the health-insurance system through industrial accidents in Great Britain is not very great, and, in view of the substantial contributions by the employer to the health-insurance fund, it may be disregarded.

In the United States, the corresponding provisions of the compensation acts place us in this respect between Germany and Great Britain. In most of the American acts, a waiting period of two weeks has been established, and only in a few states is it limited to one week. The two weeks' waiting period represents a very serious problem; it has called forth severe criticism alike from labor organizations and from many social-insurance experts. It leaves a very large number of accidents without any compensation. Efforts toward its abolition, or reduction to not over one week, are being made. Unless these efforts are successful before health insurance has been introduced there is serious danger of a part of the cost of compensation being shifted over to the health-insurance funds. In itself this cost may not be so very high, but, by increasing the apparent cost of health insurance, it may injure the cause of the latter.

And yet there is undoubtedly a material administrative advantage in the very large number of minor injuries being handled by the health-insurance organi-

zation, whatever the type of the latter may be. Being democratically managed, it offers less incentive to malingering and exaggeration, and since it requires a comprehensive organization of medical help it may be able to furnish this at a lower cost than does the present organization of accident compensation.

Co-operation between the two systems is something very different from shifting a part of the cost from the employer to the employee. A workable agreement between the two systems, embodied in legislation, by means of which most of the minor cases would be handled by the health-insurance carriers, while the cost of such cases would be reimbursed from the accident-compensation fund, would furnish a constructive contribution to the practice of social insurance.

The health-insurance bill of the American Association for Labor Legislation introduced in the legislatures of Massachusetts, New Jersey, and New York during the recent session provides that "benefits shall be paid for any sickness or accident or death not covered by workmen's compensation." The question has been raised as to whether this paragraph excluded cases of industrial accidents, remaining uncompensated because they do not extend beyond the waiting period (2 weeks in all the 3 states), and furthermore whether benefits would be payable for any part of the waiting period in case of accidental injuries extending beyond the waiting period. The formal decision would seem to depend upon the in-

terpretation of the exact language of the law, which may be different for the two groups of cases outlined above. It may be questioned whether an accidental injury which does not extend beyond the waiting period is covered by the compensation act, though the fact that even in such cases the right of suing the employer is denied would seem to point to a positive answer. If the waiting period under health insurance is shorter than for accident compensation (under the bill referred to only 3 days) there is no good reason why the injured workman should be less cared for than the ill workman.

Workmen's compensation legislation being what it is in this country, there is another important aspect in which the health-insurance system will supplement accident compensation—and that is medical aid. It seems to be preposterous even to require an argument that the need of thorough and sufficient medical and surgical aid in case of industrial injuries should be fully satisfied. Yet the amount of medical aid furnished under compensation is restricted in almost all the acts, and in most of them to such narrow limits as 2 weeks, with an additional money limit as a further restriction.⁵

⁵ Two weeks in Rhode Island, Oklahoma, Iowa (money limit \$100), Louisiana (\$100), Vermont (\$75), Montana and New Jersey (\$50), Maine (\$30), and Pennsylvania (\$25, and in exceptional cases \$75); only 1 week in Texas. No provision for medical aid in Arizona, Alaska, Kansas, Nevada, New Hampshire, Hawaii, Washington, Wyoming, and the United States employees' act of 1908.

In all these states the health-insurance system if established would be called upon to fulfil a very important function in connection with, and bear a substantial part of the cost of, accident compensation. It may well be, that this function would be more efficiently and more economically fulfilled by the health-insurance organization, because of its medical-aid organization. The more reason, however, why the principle of reimbursement from the accident-compensation fund be insisted upon.

HEALTH INSURANCE AND OCCUPATIONAL DISEASES

Until recently Great Britain was the only country whose compensation act specifically, and not by construction, recognized occupational diseases as a basis for workmen's compensation. By judicial construction several American states have accomplished the same purpose, and at least one state, California, has amended its act so as to bring all occupational diseases under the law. But the practice is far from uniform. It goes without saying that where occupational diseases have been left out of the compensation acts, they would be covered by the health-insurance law. But the fiscal principle of the shifting of cost is seriously involved here. Besides, if the health-insurance benefits be limited in their extent, as compared with accident compensation, there may still remain a very important argument in favor of bringing these cases under the compensation act. This is especially true in regard

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to cases of occupational diseases resulting fatally.

The basis of compensation, that injuries due to the occupation should be paid for entirely out of the cost of the product, is evidently applicable as fully to occupational diseases as to industrial accidents. The difference is only in the manner of occurrence—sudden in an accident, gradual in case of disease, evident and violent in accident, hidden and insidious in disease. In fact, for the purpose of occupational diseases California simply changed the word "accident" to "injury" in the compensation law; and the decisions in favor of covering occupational diseases in other states are usually based upon a broad interpretation of the word "injury" to cover diseases as well as accidents.

There are two arguments which are mentioned in support of the contention that occupational diseases should be paid out of the health insurance rather than out of the compensation fund.

1) It is argued that the very slow process of most occupational diseases makes the placing of the responsibility upon the individual employer (usually the last employer) very unfair. The difficulty of determining where and when the disease was originally acquired is a real one. But its importance is exaggerated. A sensible system of compensation presupposes insurance which equalizes the cost among all employers of each industry, and the individual employer is not responsible beyond his stated premium.

2) It is further argued that it is still more difficult to determine in many cases whether the disease is occupational or not, i.e. whether the particular case was due to the occupation, whether it was incurred in the place of employment at all. This difficulty, which may be a very real one, evidently arises from the lack of a precise definition of the term "occupational disease." Surely no such problem could arise in case of lead poisoning of a painter, a caisson disease of a tunnel worker. It is true, however, that under the broad definition of injuries cases of typhoid, tuberculosis, etc., were compensated in certain American states, (Massachusetts, California, Wisconsin) where there seemed to be evidence that these had arisen in connection with the employment.

The final division of responsibility must necessarily rest with the compensation legislation, since the health insurance scheme must handle all the left-over cases. But a rational line of division would be to place the responsibility for the specific occupational diseases upon the compensation system; while in the case of general diseases it would prevent a good deal of acrimonious controversy, if the health insurance scheme accepted entire responsibility for them. In so far as some industries may be responsible for an unusual amount of this general sickness, it is a problem for rate adjustment according to hazard to be discussed more fully in a subsequent chapter.

HEALTH AND INVALIDITY INSURANCE

The relation between these two branches of social insurance is even more important than the last two or three problems discussed. A definite decision concerning this is necessary at the very outset, because a good many problems of organization and finance are dependent upon it. It will be necessary, therefore, to go into some detail concerning this question.

Theoretically, it is not easy to draw the dividing line between sickness and invalidity. The substitution of the English term "health insurance" for the German term "sickness insurance" makes any line of distinction still more difficult. One merges into the other. Under sickness so-called acute attacks are usually understood. Invalidity is permanent (or at least chronic, prolonged) illness and disability, or disability due to previous illness. Qualitatively, also, sickness is understood to carry with it total disability for the time being (or else the sick benefits are not granted), while the definition of invalidity may be more lenient, and may be interpreted to mean a substantial reduction of earning capacity, due to failing health and strength. Thus, invalidity gradually shades into old age at the other end.

It is quite clear that as an economic problem invalidity, when given this broader interpretation, is of equal importance with that of sickness, and, as far as the individual cases are concerned, of even greater importance. There can be no question as to the desir-

ability of the insurance method of provision against it. The real problem is whether invalidity for insurance purposes should be merged with sickness, on which it borders on one side, or with old age, on which it borders on the other; or whether, finally, it should be made a matter for distinct treatment.

The predominating method under compulsory health-insurance systems is to deal with temporary total disability, and leave invalidity to the old-age insurance systems. That is essentially the German plan, followed by most continental systems. Under this system temporary invalidity may be treated by the health-insurance institutions, primarily as far as periods of recuperation from acute illness are concerned; but outside of that a definite time limit exists beyond which the disabled cannot be cared for by the health-insurance carrier.

In Germany, the dividing line between sickness and invalidity is the maximum limit of 26 weeks (raised in 1903 from the original 13 weeks' limit) which individual sickness-insurance funds may increase to a year. The invalidity and old-age insurance system handles both the cases of permanent invalidity and also the cases of sickness extending beyond the normal sickness period. The distinctive feature of the German system is that invalidity is defined as inability to earn more than one-third of the normal amount, and therefore embraces what in the jargon of compensation is known as permanent partial disability, as well as cases of total permanent disability.

In Denmark, the system being voluntary, individual associations are permitted to determine the details for themselves; but according to the law money benefits can be granted only in case of actual sickness and complete disability, not partial disability or invalidity. As a matter of fact, very few insurance funds grant benefits for over 18 weeks.

In Great Britain, on the other hand, invalidity insurance is joined with sickness into one system, so far as organization and finances are concerned, although the benefits are different. The invalidity benefits are termed "disablement benefits" and may be given for life, while sick benefits are payable for 26 weeks only. The definition of invalidity is strict and narrow, including only total disability, and is, therefore, more comparable to the benefits given in Germany to cases of sickness extending beyond 26 weeks, than to the German invalidity benefits.

With the two great precedents of Germany and Great Britain entirely at variance with each other, the question as to the comparative advantages of the two systems is not an easy one. Actuarially the treatment required by the two systems is not at all similar. As will be explained at greater length presently, when the financial basis is studied, sickness insurance deals mainly with a constant charge. While the rate of sickness increases with age, the rate of increase is not very great, and the average age of any industrial group is not very much subject to change.

Since the maximum cost of any one case is limited, substantial reserves are scarcely necessary.

Financially, sickness insurance is elastic; deficits, if any, develop rapidly and may be rapidly corrected. For this reason the German system can afford to leave the financial problems to the determination of the separate sick funds.

On the other hand, invalidity, at least in its broader interpretation, is largely a result of advancing age. Like old-age insurance, invalidity insurance requires substantial reserves, if a rapid increase in cost of such insurance is to be prevented. Invalidity insurance is therefore a matter for long-term contracts; it is a permanent agreement which must be subject to strict control if the solvency of the insurance-carriers is to be guaranteed. For this reason, invalidity insurance (like old-age insurance) in Germany is carried on by the larger insurance institutes, which are practically state institutions and are all the time under strict government control. To insure a fair balance between income and expenditures a very careful actuarial study of invalidity statistics must precede the preparation of the rates.

When invalidity benefits are combined with sick benefits, as was done in Great Britain, and one rate of contribution is quoted for both, all the actuarial difficulties of invalidity insurance are extended over the entire health-insurance system. The solvency of the health-insurance carrier may be only apparent, because the funds which should have been accumulated

to meet the future increasing charge of invalidity may have been utilized in payment of sick benefits. Nevertheless, if the health-insurance system is based upon compulsion to insure with a prescribed carrier, the financial difficulty may not be fatal. So long as the insurance-carrier is sure of its hold on a definite group of insured, it can meet the increased cost by distribution among all of them. The excessive burden may be felt, but cannot be escaped. But the British system unfortunately was based upon freedom of choice between insurance-carrier, and right of transfer from one carrier to another. Thus the financial problems became doubly complex. With a system of "level premiums," with which the public is familiarized through life insurance (i.e., premiums which should be increasingly larger, but which are recomputed to equal annual amounts, so that in the early years the premiums represent an over payment, and in later years are below the necessary amount, and the reserve accumulated in earlier years is gradually absorbed in the course of years), the entrance of an insured of advanced age would represent a loss to the insurance-carrier, unless the reserve value at his age is paid. The British system, therefore, required a very complex system of bookkeeping with reserve values for each age, and cross-entries between different funds for every case of transfer from one fund to another. This again required the centralization of all funds in government institutions. Thus many difficulties of accounting and actuarial prac-

tice were created, which were increased by the very uncertainty of actuarial data upon which all computations were made. A large share of the criticism of the British system emanates from these difficulties, while the German system dealing with sickness only has the advantage of simplicity and freedom from actuarial complications.

These actuarial difficulties would have been even greater if the British definition of invalidity were as broad as that of the German law. The British definition approaches that of the "total permanent disability clause" under modern American life insurance contracts,* which but rarely comes into play.

It is evident that true industrial invalidity due to (possibly premature) failing of earning power is a

* Within the last 20 years the practice has rapidly developed to add to the life insurance contract a provision waiving the payment of premiums in case of total permanent disability. An additional charge is usually made for this clause, which is, however, so small as to be almost negligible, not so much because total permanent disability is so rare, but because the mortality among those suffering from it is very high. (See "The Total Disability Provision in American Life Insurance Contracts," by Bruce D. Mudgett, Ph.D. (1915). The Travelers Insurance Co. recently reported that it paid claims under such clause in 43 cases, of which there were

Tuberculosis	in 14 cases
General paresis	" 19 "
Other diseases of nervous system	" 11 "
Cancer	" 3 "
Injuries	" 3 "
Other cases	" 1 "

43 cases

much more comprehensive concept and a much more frequent occurrence. Again, for lack of statistics, definite quantitative statements cannot be made. It is known, however, that the similar condition of partial permanent disability is very much more frequent than total permanent disability. According to the Standard Accident Table, which represents the author's effort to construct a general table of distribution of industrial accidents according to the gravity of the injury, there may be expected out of every 100,000 accidents 133 cases of permanent total disability and 4,742 cases of permanent partial disability. According to the German interpretation all cases with the earning capacity reduced to one-third or less constitute invalidity. Some 15 per cent of these cases have suffered a disability of 66 2-3 per cent or over, or have retained an earning capacity of 33 1-3 per cent or less—711 cases per 100,000 or between 5 and 6 times as many as there are cases of permanent total disability. Under effect of disease, rather than injury, coupled with the effect of advancing old age, the number of these lighter cases may be still more numerous. Nor is the mortality among these cases as high as among the hopeless cases of total invalidity.

Adding this feature to the ordinary limited health benefits would, therefore, tremendously increase the possible financial burdens and perhaps make altogether impossible the particular system of health insurance outlined in these pages.

An explanation of the differences between the German and British methods may be found in the different provision made by the two countries for old age. Germany with its system of compulsory old-age insurance could very readily extend the activity of its insurance institute to cover invalidity as well. The British National Insurance act found Great Britain already in possession of a system of non-contributory old-age pensions. Public opinion would not have countenanced the addition of non-contributory invalidity pensions (although there would have been a precedent for it in the French old-age pension act of 1907, which includes invalidity), and a separate organization for invalidity probably appeared too complex. A practical way out of the difficulty appeared in the combination (rather unusual in the history of social insurance) between sickness and invalidity insurance.

In this country the field is open for either method; we have neither compulsory old-age insurance nor non-contributory old-age pensions, nor has either of these two methods as yet entered the domain of practical politics. Both methods have already received the support of some theoretical propaganda; as far as popular support is concerned, the advantage seems to be on the side of non-contributory pensions, which have achieved considerable popularity among organized labor. Some preferences either for or against inclusion of invalidity may come as a result of partisanship in favor of either of these two

plans. Adherents of non-contributory old-age pensions may prefer to see the problem of invalidity settled in connection with health insurance, with the hope of thus facilitating a system of non-contributory old-age pensions.

It should not be assumed, however, that these two problems stand to each other in the relation indicated. The question of comparative advantages of non-contributory pensions and compulsory insurance for the purpose of old-age relief may be decided on its own merits in due time. The present task of carrying through a system of health insurance will be very much simplified if it be kept separate from that of invalidity insurance.

Besides, the decision in favor of keeping these two branches of insurance actuarially distinct need not at all interfere with the simultaneous introduction of both systems, even by the same legislative enactment, as, for instance, the entirely independent systems of health and unemployment insurance have been established by the British National Insurance act of 1911, and as accident compensation and sickness insurance have been combined in the same Swiss law. Nor would it make some co-operation between the administrative organisms of the two systems impossible. The only step that is here urged is that the actuarial foundations of the two systems be kept independent of each other, and that the advantages of freedom from actuarial difficulties be preserved for the health-insurance system, as they easily can be.

V

MEDICAL BENEFITS

THE direct object of health insurance is the complete or at least partial restitution of the losses sustained through sickness. This demands two broad divisions of service: (1) a money benefit during loss of earning power; (2) restitution of cost of medical and surgical aid, or the direct grant of such aid, in all its ramifications, in kind.

The necessity of medical aid, as a part of a health-insurance system, would seem quite obvious. Nevertheless, it must be remembered that in as many as nine American compensation acts¹ this feature is completely lacking, and perhaps the most amazing thing is that in Washington and Wyoming this most essential omission took place in connection with a state insurance plan. In one tentative American draft of a health-insurance bill which reached the writer, no provision was made for medical benefits. This is also rather frequently true of voluntary American sickness-insurance schemes, as operated by trade unions or establishment funds, while, on the other hand, in the large cities of the eastern states,

¹ Alaska, Arizona, Hawaii, Kansas, Nevada, New Hampshire, Washington, Wyoming, United States employees' compensation act of 1908.

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many co-operative organizations (lodges, etc.) are found among foreign-born workmen which endeavor to grant cheap medical aid only, independently of money sickness benefits. It cannot, therefore, be stated too emphatically that only through a combination of both of these forms of relief can the social purposes of health insurance be accomplished.

It is rapidly becoming recognized that the most important, though indirect, social purpose of insurance is its preventive effect. The recent sensational charges against fire insurance were largely based upon the assertion that the effects of its methods were contrary to prevention, and the defense pointed at the preventive effect of schedule rating. The broad movement for "safety first" resulting from compensation legislation is a matter of recent history, and the various compensation-insurance carriers vie with one another in extending measures of prevention in order to establish for themselves the right to continued existence. Even in the old and well-established business of private life insurance, the movement to accomplish not only successful selection, but also prevention, is gaining strength and finds expression in the Life Extension Institute, in the nursing service, in periodic examinations of insured, in the recognition of social responsibility toward the rejected applicant, and so forth.

Perhaps in no branch of insurance is the road to prevention so clearly indicated as in health insurance through the granting of medical aid. So far as the

curative effect of treatment of individual cases is concerned the same situation is found in accident compensation. But only in rare cases are workingmen subject to repeated industrial accidents, and the effect of a successful treatment of one injury in preventing another is somewhat far-fetched. But in health insurance the connection between one attack of illness and another is direct and obvious. Every case of illness is, strictly speaking, a predisposing cause for subsequent illnesses. Even in case of those forms of sickness which are followed by immunity, a general debilitating effect cannot altogether be avoided. Naturally the prevention of the destructive effects of illness depends to a large extent upon treatment and care, and the organization of a proper system of medical aid for the masses is perhaps one of the greatest factors in the modern movement for life conservation. In fact, though in case of sickness of the bread-winner the obvious, immediate need may be for financial relief, it would be no exaggeration to say that, so far as final results are concerned, proper treatment and a rapid cure of the patient are matters of far greater moment.

It is scarcely necessary to state that in Germany, Great Britain, Denmark, in fact in almost all countries which have systems of health insurance worth the name, medical aid is an integral part of the system,²

² The total omission of medical aid in Ireland was the only distressing exception, until the passage of the act of 1913 by Netherlands, granting money benefits only.

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except perhaps in Russia, where medical aid has for 50 years constituted a legal obligation of the manufacturer to his employee, and this condition has not been disturbed by the sickness-insurance law of 1912. In this country, because of the appalling spread of *nostra*, cure fads, faith-treating, Christian Science, etc., some considerable opposition to an effective system of medical aid in connection with a public insurance system may be expected. But whatever the political necessities of various "local situations" may bring, the expert draftsman of legislative proposals should not be willing to assume any compromising attitude in this all-important matter.

EXTENT OF MEDICAL AID

While all national health-insurance systems are alike in making some provision for medical aid, there is great variety in the extent and methods of such service. It is well, therefore, to begin by enumerating the various headings into which the broad term "medical aid" may be divided: (1) ordinary medical aid; (2) ordinary surgical aid; (3) obstetrical aid; (4) major surgical aid and treatment by specialists; (5) dental care; (6) drugs and ordinary surgical supplies; (7) special apparatus and appliances; (8) hospital care; (9) sanatoria; (10) convalescent homes and institutes.

The list will emphasize the complexity of the problem, which may not otherwise be obvious to the lay-

man. The division may appear unnecessarily minute. The ten forms, or perhaps degrees, may be summarized in the following three groups: (A) medical treatment (1-5); (B) supplies (6, 7); (C) institutional care (8-10). When thus stated the necessity for each group becomes obvious; drugs or other supplies may become necessary in all cases and, in some, effective results cannot be expected without institutional care. In the three countries selected as types, some provisions are found in regard to each of the three large groups of aids, but in each country the legislative situation is different.

The Danish system being optional, the law can establish only minimum requirements as a condition of recognition and of subsidy. All three forms of service are recognized in the law, but the extent to which aid must go cannot in the nature of things be specified. Nevertheless, it is significant that the recognized societies are *required* to furnish hospital treatment *when necessary*.

While the system is compulsory in Germany, the principle of local autonomy limits the law to minimum requirements only, and further extensions of the service are left to the individual funds. Even the minimum requirements, however, are fairly extensive; they include medical attendance, supply of medicines, eyeglasses, trusses, and other minor therapeutic appliances. This would seem to be grouped under the headings 1, 2 (possibly 4 with limitations), 6, and 7 (with limitations). In regard to institutional care,

the language of the law is not exacting, *permitting* the funds to substitute hospital treatment for ordinary medical care, although, as a matter of fact, the development of institutional treatment in Germany has been very extensive.

Finally, Great Britain is perhaps the only country which embodied in its health-insurance law a definite and almost uniform system of medical aid. This is consistent with the general principle of national uniformity in the British system. The general provisions of the act include "adequate medical attendance and treatment," ordinary drugs and supplies, such other appliances as may be included by administrative regulations, and the much-discussed "sanatorium benefits," to be granted only in cases of tuberculosis and such other diseases "as the Local Government Board may appoint." Further extension of the medical benefits is permitted as optional benefits. As will be explained elsewhere, the situation in Great Britain is perhaps the reverse of that in Germany, in that the actual conditions are very much inferior to those laid down as obligatory in the law.

In our effort to establish here definite standards of medical aid, the two aspects of the problem must be kept separate: the desirable standard of actual accomplishment, and the standard of legal requirement. It is obvious that the two do not and, moreover, need not always concede. Poor administration on one hand, or unworkable legislative standards on the other, may make the practice much less satis-

factory than the law. But it is possible under the system of local autonomy and co-operative initiative, such as is outlined in this book, for the actual results to be vastly superior to the minimum requirements of the law. An agreement concerning standards becomes imperative at first in formulating the legal requirements. How far shall they go with regard to medical aid?

The writer's own choice is based upon a deep appreciation of the utmost importance of proper medical care, perhaps due to a few years of active practise of the medical profession. Obviously, however, it is useless to put requirements upon the statute books, which society on a certain cultural level is utterly incapable of meeting. If a national health-insurance act were in contemplation, such an act could embody as a minimum requirement nothing which even a frontier community, such as Montana, or a backwoods community of the South could not reasonably comply with. But since health-insurance legislation, like compensation legislation, will most likely proceed within state lines for some years at least, it would be decidedly wrong to establish no higher minimum requirements for New York or Massachusetts than would appear adaptable to Wyoming or Florida.

Limiting our discussion for a moment to the states of a higher cultural level, we may ask, What shall the minimum requirements be, as expressed in the legislative act? Up-to-date homes for convalescents or Zander institutes may not be expected in every county

and school district, and the development of such methods of cure may for the time being be left to the voluntary efforts of the local health-insurance carriers. But outside of such extreme demands, it seems to me, nothing less than thoroughly "adequate" medical and surgical care (to utilize the splendid word of the British act), including supplies, apparatus, hospital and sanatorium treatment, is justified.

Of course this is a much broader program than the amount and degree provided in Great Britain either by the language of the law, or in actual practice, or even in Germany by the general law (though not as actually applied), and yet this formula is the least that conforms with the ideal of the life-conservation movement of this country. Medical aid is not worth having unless it conforms to the proper standards of the medical science of the time. If medical care under a socially organized system of sickness insurance should degenerate to a rapid, careless prescription of drugs by hurried and overworked physicians, then the entire preventive effect of the system would be completely nullified. We may well discuss the extent of economic relief which society may grant to its disabled wards, but the first and absolute prerequisite is that it do all that can be done to cure them. To insist that less is sufficient for the workman, because he is a workman, is to destroy altogether the constructive character of the entire health-insurance idea, considered as part and

parcel of the modern movement for scientific prevention of destitution. Wherever, therefore, social conditions at all permit it, all the ten forms of medical care enumerated above must be included in the minimum requirements of the law.

ORDINARY MEDICAL AND SURGICAL AID

The necessity for ample and efficient surgical aid in addition to ordinary medical care is, or should be, quite self-evident. In the entire criticism of the practice of the British national health-insurance system made by the Fabian Research Department^a nothing carries so much weight as the evidence that even the performance of ordinary operations is not always guaranteed to the insured workman. Nor is it necessary to argue that competent obstetrical aid is an absolute necessity. This feature, however, will be dealt with at greater length presently in connection with the entire problem of maternity insurance.

In a "backwoods" or frontier community the requirements of expert surgical aid for major operative work and of treatment by specialists may appear extravagant, and yet a little reflection will readily show that if the system of health insurance is at all to produce the desired results, these services must be included among compulsory requirements. It is pre-

^a Committee of Enquiry, Sidney Webb, Chairman. See *The New Statesman*, Special Supplement on the Working of the Insurance Act, March 14, 1914.

posterous to guarantee to the ill workman the diagnosis in case of appendicitis, or cancer of the stomach, but not the operation; it is preposterous to expect him in case of some special forms of disease, such as diseases of the nose, throat, or eye, or of the nervous system, to be satisfied with care by an incompetent "general practitioner," or family physician; for this would reduce the quality of care given even below that to be obtained from free dispensaries.

And it is quite obvious that the less available these higher forms of medical service are in certain communities the more imperative it is that the new system of health insurance establish them. For in the progressive communities public or private charity always stands ready to render aid in an extreme case and emergency, but in the next community the poor man frequently suffers serious injury to health or pays with his life for this entire absence of specialized and expert medical aid. In the majority of German cities this specialized medical service is being granted, and in progressive American communities it is equally possible. It is only because of an archaic and faulty organization of medical practice that the concepts of specialized expert medical service and expensive service have been merged into one in public opinion. The necessity of specialization in medicine has been recognized at the same time that facilities for such successful specialization have grown. The practical methods for securing the treatment of special diseases by special experts only, and at no exorbitant

cost, can be brought about by proper organization, of which more will be said when the problem of organization of medical aid is reached.

But it cannot be stated too emphatically right here, that whatever the difficulties, a system of health insurance is exceedingly faulty which avoids these difficulties by simply omitting these important branches of medical service, as the British system does in actual application. The legal demand for adequate medical aid is not met, if no expert diagnosis through a consultant, no bacteriological, chemical, or physiological examinations, no X-rays, no expert specialist treatment, and no serious operation are furnished. In view of the large amount of evidence collected by the Fabian Committee, the charge seems justified, that on the whole medical treatment is being provided under the act only for the minor ailments of the insured persons.⁴

DENTAL CARE

The general principles enunciated above are equally applicable to the question of dental care. Here again some constructive steps will be necessary, as the situation even in Europe is far from satisfactory.

In Denmark no requirement as to dental care is contained in the act, and there is no evidence that the recognized societies furnish it to any extent. The

⁴ *The New Statesman*, Special Supplement, March 14, 1914, p. 6.

British act refers to dental aid as one of the permissible "additional" benefits. The new German act specifically refers to dentists, but the extent of dental care is not prescribed. Presumably, simple measures like extraction are considered an essential part of medical aid. The tendency among larger funds is to provide for extensive dental service, and a few funds even provide part of the cost of prosthetic dental work (artificial teeth, crowns, bridges, etc.).

The superior development of the science and practice of dentistry in the United States furnishes a basis for a more liberal and more satisfactory provision of dental aid. Scientific dentistry has long been recognized in this country as a necessity rather than a luxury. In establishing the minimum cost of a standard of living, the Massachusetts minimum-wage board included a small amount for dentistry. It is true that dental diseases are seldom sufficiently severe to interfere with earning capacity except for very short periods of time. But the harmful though insidious results of dental defect upon the general state of health have already been recognized. "There is," says Professor Osler, perhaps one of the world's greatest physicians, "not one single thing more important to the public in the whole range of hygiene than the hygiene of the mouth. If I were asked to say whether more physical deterioration was produced by alcohol or defective teeth, I should unhesitatingly say defective teeth."

And the recent discoveries of a very close de-

pendence of most rheumatic affections, including the very serious affections of the inner lining of the heart and its valves, upon loci of infection in the mouth and particularly in the teeth, have placed a specially high value upon scientific care of the teeth.

Many investigations have established the great prevalence of dental diseases among all ages and groups of the masses. Wage-workers, themselves, are also to some extent aware of these effects. The amount of money spent by the poor for dental work is rapidly increasing, but unfortunately it is seldom spent so as to produce the necessary results. Within recent years popular dentistry has been grossly commercialized through the development of so-called "dental parlors." In these the pressure is always for prosthetic dentistry because that is the most expensive and therefore the most profitable to the commercial dentist. The masses are never told that this is the least useful and most objectionable form of dental aid, nicknamed "septic" dentistry by some experts in the line. The cheaper and much more effective prophylactic work is disregarded. Within recent years, however, the hygienic importance of early dental aid has been so well recognized by scientific students that organization of regular dental departments in responsible hospitals is rapidly becoming the rule. The inclusion of systematic dental aid as a required branch of medical care is urged here, therefore, because of its general hygienic effects, and also because it will prove economical in

the end by substituting early and cheap satisfactory relief for delayed, expensive, and often harmful "gold teeth."

MEDICAL AND SURGICAL SUPPLIES

A difference of practice may also be observed in the furnishing of the material aids to medical care—drugs, supplies, etc. In the voluntary system of Denmark the furnishing even of drugs is optional, with very unsatisfactory results. According to the latest data,⁵ more than half the societies (57 per cent) entirely refused this service. Only 18 per cent paid for the entire cost; while the remaining 25 per cent contributed only a part of the cost. Thus the results of the voluntary system are seen to affect the quality of the service very seriously by leaving an economic motive for saving on necessary drugs and supplies. In both the British and German acts, the furnishing of drugs and ordinary supplies is compulsory. As to the more expensive surgical and medical appliances, the British act leaves the question of how far they shall be furnished to administrative regulations by the insurance commissioners. The German law, in accordance with its general methods of establishing minimum standards only, makes the supply of "eyeglasses, trusses, and other minor therapeutic appliances" compulsory upon the

⁵ *Medical Benefit in Germany and Denmark*, by I. G. Gibbon, p. 153.

sickness funds. In actual practice many German funds go far beyond that, and provide artificial limbs, artificial eyes, etc. In Great Britain the situation is unfortunately just the reverse. The actual practice, as established by administrative regulations, is very inferior to the plain intent of the law, as neither trusses and elastic stockings, nor crutches, and not even eyeglasses or syringes, are furnished, not to speak of such "luxuries" as artificial limbs.

Perhaps nothing so strongly brings out the shortcomings of the British Health-Insurance System as compared with what the German system has accomplished, as this petty parsimony as to necessary supplies. A few interesting figures from the report of the Leipzig Sick-Insurance Fund may here be quoted.* It is true that this is perhaps the largest and best-managed sick-insurance fund in Germany with a membership exceeding 200,000, and handling 90,000 cases of illness a year, but for this very reason its experience is extremely valuable as an object lesson of what an efficient system of health insurance is and ought to be. In addition to ordinary drugs this insurance institution furnished during 1912 eyeglasses at the cost of 31,307 marks (\$7,451), trusses, etc., to the amount of 34,716 marks (\$8,262), even artificial eyes (424 marks or \$101). It administered 25,292 special medicinal baths and massage treatments at the cost of the large sum of 75,327 marks

* *Geschäfts-Bericht der Allgemeinen Ortskrankenkasse für die Stadt Leipzig für das Jahr 1912.*

(\$17,928); electric and other specialized methods of treatment (in Zander institutes), at the cost of 48,233 marks (\$11,479), and prosthetic dental work for 26,688 marks (\$6,352). Whether the amount was sufficiently large, it is impossible to tell offhand; but the mental picture created by these statistical data is of a thorough and careful treatment of the ailments and the needs of the insured workmen. What a pitiful contrast is presented by the situation in England when one reads the pathetic arguments of the Fabian Report, that the English sufferers from hernia who are assured "adequate medical treatment" under the law, continue to go about without trusses, unless able to buy one from their own savings; that "a workman, forbidden to resume work without a truss and yet given no truss, made himself a poor substitute out of cardboard and rag, and went to work at whatever risk to his future health."

Take the matter of spectacles, for instance. The experience of the Leipzig fund indicates that thousands of its members annually are in need of glasses, that undoubtedly many of them would probably go without glasses or buy cheap and injurious ones if not furnished by the insurance fund. Yet the failure to provide proper accommodation by glasses not only must interfere with the earning capacity of the sufferer, but leads, according to the evidence of modern medical research, to serious disturbances of the nervous and even digestive systems.

The limitations of the British system fully justify

the severe criticisms made by the Fabian committee. "Medical care" is nothing but a delusion, unless the necessary mechanical appliances are available to carry into effect the advice given by physicians. Some appliances may be expensive, but it is just because they are expensive, and because they are required in rare cases only, that they can be furnished by the insurance method much more easily than by individual purchase. Moreover, as measured by the amount of relief granted, and even by the restoration of earning capacity, these appliances, as trusses, elastic stockings, eyeglasses, or even artificial limbs, are the cheapest forms of surgical aid. A system of public health insurance is derelict in its duty if it fails to make all possible efforts for a cure, or at least alleviation of suffering, which modern medical science permits. A normal act has, therefore, the choice of only two methods: either to enumerate a very detailed, almost exhaustive list of permissible appliances to be furnished according to proper medical advice, or to use the broad formula of the Wisconsin compensation act, and to establish in plain terms the right to *all* necessary aids to treatment.

INSTITUTIONAL TREATMENT

The conditions outlined above may well apply to all communities. In regard to the third group—namely, institutional treatment—the problem is somewhat more complex.

Hospital treatment is becoming more and more important in dealing with serious illness, partly for technical and partly for social reasons. There are diseases which in the very nature of things require constant medical attention. It is true that recently medical science has recognized certain disadvantages in hospital treatment, and has indicated conditions under which home treatment may be equally effective medically and more desirable for psychologic reasons. But this may be realized only under conditions which are quite utopian as applied to most workingmen's homes.

Ordinary hospital treatment is recognized as a necessity in almost all European health-insurance systems. The Danish law requires the recognized societies to furnish it whenever necessary, and some arrangements to supply it are made by practically all societies. The legal requirement that hospital charges to the recognized societies must be only half the regular charges proved a large inducement. As general hospital facilities are good, there is seldom any necessity for special hospitals for the exclusive use of the societies. While the German act is not very exacting in its language, as a matter of fact there has been a very extensive development of hospital treatment in connection with the German system. Practically all important sickness funds furnish it, and in many of them from 10 to 15 per cent of the total budget is expended for this purpose.

The development of special sanatoria and con-

valescent homes has been largely optional. Very little has been accomplished in Denmark; on the other hand, in Germany, the development of such institutions, largely owned by the sickness funds themselves, has been very rapid. Thus, e.g., the Leipzig fund has three convalescent homes and a special Zander institute for treatment of functional disorders by special exercises, Munich has two sanatoria, Hamburg two convalescent homes, etc. This is entirely independent of the special institutions established by the invalidity insurance institutes operating under the old-age and invalidity insurance laws, which furnish a good deal of medical aid to those insured. It is the invalidity institutes which have provided some 65 sanatoria for special treatment of tuberculosis, with very important results.

The whole problem of institutional treatment in Great Britain is still in a very unsatisfactory condition. The so-called sanatorium benefit is limited to tuberculosis and such other diseases as the Local Government Board may designate, but as yet no others seem to have been so designated. The sanatorium benefit is therefore comparable to the tuberculosis treatment of the German invalidity insurance, or would be, if in reality it were not so much inferior to the standards of the law. The sanatorium benefit may be given in form of dispensary or even home treatment, and in actual practice often resolves itself only into supplementary allowances to the physician for medication in cases of tuberculosis, which should be a

constituent part of the ordinary medical aid. The serious obstacle to the proper development of this benefit is the appalling insufficiency of hospital facilities in Great Britain; ' but this, it was hoped, would be gradually overcome through special appropriations for construction of tuberculosis sanatoria. How far this program may be continued in face of the financial problems created by the war remains to be seen. Nevertheless, even if the reality is very much below the standards established by the law, it has accomplished some good by attracting public attention to the lack of hospital facilities, and creating a constant, urgent demand from the insured for correction of this evil.

It is evident that in the regulation of institutional treatment, more than in any other branch of medical care, a certain latitude may be allowed out of consideration to "local conditions." Each state may decide for itself how far institutional treatment may be made obligatory upon its health-insurance system. If the state is territorially large, and conditions throughout are not uniform, the actual extent of institutional treatment may be left to the funds themselves, or to administrative regulation.

Nevertheless simple acceptance of prevailing con-

' Modern sanitary science demands 5 beds for every 1000 of population. According to the researches of the Fabian Committee, London and the adjacent counties have about 2 beds per 1000, some fifteen counties have from 1 to 2 beds, and most counties have even less than 1 per 1000.

ditions as necessarily final would be out of harmony with the constructive character of this legislation. A modern community cannot claim any cultural standing if hospital facilities for treatment of grave illness are insufficient. Unless the geographical difficulties are very serious, or population very sparse, and means of transportation unsatisfactory, an earnest effort should be made, in conjunction with health-insurance legislation, to build up a sufficiency of hospital facilities. The same is true of special sanatoria for consumption, while the further refinements, such as special institutes and convalescent homes, may for the present be left to voluntary communal effort. It may appear that the joining together of these two issues is somewhat irrelevant, and that a state will, or will not, have sufficient hospital facilities, irrespective of all health-insurance legislation. But the obvious reply is that the insurance system creates a fund, out of which hospital treatment for its members may be paid (as explained presently), that this fund will be constituted largely through contributions from the insured themselves, and that they have an implied right to be furnished with not only purely formal "medical advice" but also effective medical aid. There are no difficulties, except financial ones, to the increase of hospital facilities, and the insurance system is designed for the very purpose of meeting such financial difficulties.

CONDITIONS OF MEDICAL AID

Since insurance is a contractual obligation, some limitations are often inevitable, but comparatively little need be said concerning the limitations of medical benefits. In every insurance contract some time limits are necessary. In private insurance the policy period and in collective insurance membership in the insurance organization carry the natural limits, while under the system as here outlined^{*} membership itself depends upon employment in an insured trade. Of course all benefits of membership must extend beyond the period of active employment into the period of illness with payment of benefits. But such extension is also subject to a limit, so long as the line of demarcation between health insurance and invalidity insurance is accepted as already explained. Just where this line of demarcation should be placed may be discussed with better advantage in connection with the money benefits.

There may be a time limit at the beginning of illness as well, which under the term of "waiting period" has become a distinct feature of compensation in the United States. This, however, is obviously inapplicable to medical aid, where promptness is a matter of greatest importance. Universally, therefore, the right to medical aid begins with the beginning of illness.

Under the same term "waiting period" an entirely

^{*} See pages 35-38.

different time limit is often meant: namely, the time which must elapse after the beginning of insurance before the right to the benefits is free from all restrictions. Strictly speaking, it is a period of probation, during which the insured person is really not insured though he may pay the necessary dues. Such a provision may be necessary under a voluntary system for the purpose of eliminating persons who might insure because they know themselves to be sick. In the Danish voluntary system such a "waiting period" of six weeks is required. But while there may be some important reason for such a period of "suspended insurance" so far as the payment of money benefits is concerned, it appears altogether unnecessary in application to medical aid. The possible abuse of the medical-aid privilege is far less important than the danger of denying aid to any one in real need of it.

A considerable amount of medical aid may be needed, moreover, in cases not requiring any discontinuance of work. In such cases any limitations upon the amount of medical aid to be furnished would be socially indefensible, since the hygienic effect of such aid would counterbalance any consideration of excessive cost.

EXTENSION TO MEMBERS OF FAMILY

Shall medical treatment be limited to the insured workers or shall it be extended to the immediate de-

pendents of the insured? At first, such an extension may be considered as altogether unwarranted. Health insurance as here outlined deals with the disabled wage-earner. The entire philosophy of social insurance is based upon the causal connection between employment and disability on one hand and between disability and unemployment on the other. The inclusion of insurance of others, even though they be members of the family, will be classed as a gratuitous application of socialist policy, and as such will call forth serious objections. Already this tendency has been disclosed in many private conferences concerning standards of health insurance.

Nevertheless, a strong inclination to include dependents is observable in all compulsory health-insurance systems. The German insurance code grants this among the many permissible extensions of the sphere of activity of the sickness funds, and the majority of the larger funds have done so, as, for example, in Leipzig, Dresden, Frankfort, Bremen, Hannover, Düsseldorf, Strassburg, Cologne, Essen, Mainz, Kiel, etc. Less common is a similar extension of the drugs and supplies benefit, but that, too, is found in many cities, such as Leipzig, Dresden, Hannover, Mainz, and Kiel, while in Cologne, Essen, and some other cities half of their cost is met by the fund. In Denmark, though the system is optional, medical and hospital treatment to dependent children under fifteen years of age is one of the required bene-

fits of the recognized societies. In the British act "medical treatment and attendance for any person dependent upon the labor of a member" is the first of the additional benefits, which may be instituted by any approved society which shows a disposable surplus after valuation, though as yet this British provision is only a dead letter.

The demands of life evidently appear stronger than any theoretical constructions. A purely formal connection between the insurance of the wage-worker and that of the members of his family may be lacking, but the social advantages of utilizing the established medical organization for the benefit of the entire working population are so great that any logical inconsistency may be calmly disregarded. The drawbacks of the present disorganized system of providing the poorer classes with medical aid are so palpable that it would be criminal to leave it undisturbed in the case of the wife and children of the breadwinner, in face of a system established presumably for his benefit. The entire purpose of this system is to eliminate any economic obstacle to the work of preservation of life and health, and surely the life and health of the wives and of the coming generation are of social value at least equal to the life and health of the laborers. With from 250,000 to 300,000 children dying annually in this country under the age of one, another 100,000 before 5, and perhaps some 90,000

in ages from 5 to 19,^{*} the tremendous value of any improvement in preventive as well as curative medicine can hardly be exaggerated. That the working-man's family needs such aid no less than he it seems unnecessary to argue. And while the families of the insured may not need it more than the rest of the population, the fact that a comprehensive system must be organized for the head of the family is a sufficient social argument for extending the benefits to such persons at least as naturally and easily fall into the same group.

Perhaps some objection to such extension may come from the medical profession, because this measure would represent a further, and for most of them a final, encroachment upon the domain of private practice, as at present conducted. The state will have to face this issue and to decide whether the conditions of practice of medicine should be adjusted to the needs of the people's health or whether these should yield to the conservatism of the medical profession.

That as a matter of fact the opposition to such extension is short-sighted, so far even as the interests of the medical profession are concerned, will appear when the questions of medical organization are discussed. It is sufficient to state at this point that at the hearing on the Mills Bill at Albany on March

^{*} The figures for 1913, covering only the registration area, with 65 per cent of the population, are: 159,435 under 1 year, 63,694 at age over 1 and under 5, and 54,779 at ages 5 to 19.

14, 1916, Dr. Alexander Lambert, representing the American Medical Association, urged such extension of the medical benefits to the family of the insured, as an amendment to the Mills Bill.

VI

MONEY BENEFIT

THE student of social problems may advocate health insurance largely with the view toward its ultimate effects upon the improvement of the health of the community, and often is concerned more with the organization and socialization of medicine, with the provision for proper sanitarium treatment which may be necessary for complete recovery from a lingering illness, etc., than the immediate financial relief. The insured workman himself almost invariably looks upon the insurance plan from an entirely different angle, and while admitting in a half-hearted way that the medical feature has its value, is very much more concerned with the size of the weekly benefit he may expect when he is compelled to "lay off" because of ill health. This attitude is shown by the almost complete absence of the medical benefit from most voluntary sickness benefit or health-insurance schemes organized by the American working class (trade union benefit funds, fraternal orders, etc.) or patronized by it (industrial health insurance). In so far as co-operative organizations for granting medical aid (lodges, etc.) exist, they are prevalent chiefly among certain immigrant elements

(Russians, Jews, Italians), and even then concern themselves largely with the treatment of the women and children. The approval of any scheme proposed by the workers will largely depend upon the provisions for sick benefit. The size of the latter will determine whether the sick worker will escape the mental anguish resulting from inability to provide for his family, whether illness will create a financial crisis in his status from which recovery is painful and slow, or whether it may be weathered in a cheerful and optimistic spirit.

But even from the point of view of preventive results the level of the sick benefit is a matter of great importance. Unless it is sufficiently large to provide at least the urgent needs, a motive will remain to return to work long before complete recuperation has taken place, and thus the effect of the health-insurance scheme in preserving life and health will be interfered with.

Until the advent of the British national health-insurance system, benefits computed in proportion to wages were practically the uniform practice of compulsory systems. The British act was the first to introduce a uniform scale of benefits for all. The practice of voluntary health-insurance organizations, on the contrary, tends more toward uniform scales.

Thus in the American health-insurance schemes of various types the rate of weekly benefits is almost universally a specified amount. Of the 19 national unions which had temporary disability provisions at

the time a federal investigation of these benefit features was made,¹ 17 granted \$5 a week, and 2, \$6 a week. Of the 346 local funds granting such benefits described in the same report, all gave specified benefits, varying between \$2 and \$10, but the predominating rate in over one-half of them was \$5 a week. The same holds true of most establishment funds, the predominating rate being \$5 or \$6, though occasionally it rose higher—even to \$25.²

It does not help much to point out that in the British system the contributions are uniform and therefore the benefits are uniform. That the same principle should govern both contributions and benefits must be conceded at once. But which principle should it be?

The comparative advantages of these two methods of compensation or insurance have already been discussed at some length in this country in connection with accident compensation. The two methods rest upon somewhat different theoretical foundations. If the sick benefit be considered in its insurance aspects, as compensation for loss sustained, the benefit should be a factor of wages, if it does not cover the entire loss. Proportionate insurance, when the insured person (or the owner of the insured property) remains a co-insurer, is known in all branches of

¹ *Twenty-third Annual Report of the (U. S.) Commissioner of Labor*. "Workmen's Insurance and Benefit Funds in the U. S.," 1903, p. 43.

² *Twenty-third Annual Report of the (U. S.) Commissioner of Labor*, n. 409.

property insurance. An entirely different theory is, however, frequently advocated, which may be designated as the theory of social need. Social insurance, according to this theory, does not aim at individual justice, is not concerned with an arithmetically accurate restitution of loss, but with the elimination of social ills—primarily that destitution which follows in the wake of impaired health. In determining the amount of benefits to be granted, the decisive factor should not be the wage loss but the need created. And the basic need of physiological necessities does not depend upon the wage level, but possibly upon other considerations, such as the size of the family. Therefore the amount of benefit should be uniform, or possibly be adjusted to the number of dependents. But whatever the comparative merits of these two theories, the decision as to the due course of procedure is a practical one, and must be based on practical considerations.

A uniform scale has certain advantages of simplicity, but very few other advantages. The wage-workers do not all live according to the same standard, and presumably there is some proportion between earnings and needs. It is true that in case of workmen of very low earning power a benefit based upon a fraction of wages may be too small even for the essential demands, but provisions for a minimum to meet this situation have already become familiar to American legislatures through compensation acts. On the other hand, the flat uniform scale of benefits

would either be too high for large groups of wage-workers and offer an inducement to malingery, or too low to be a measure of substantial relief to the better-paid workers. Especially are the arguments against one uniform scale strong in the United States. The extent of wage variations is probably very much greater in this country than in Europe, where fairly uniform conditions prevail. Within one state and even one city, common wage variations may be between \$4 and \$40 a week. Under such circumstances the problem of establishing one uniform and fair scale of benefit is a difficult one.

Judging from the experience of our compensation legislation, the actual scale of benefits may prove the gravest point of contention when legislative work seriously begins. Comparisons of what is being done in Europe may be offset by a natural tendency to follow standards already established in regard to accident compensation, since essentially the problems are identical so far as the needs of the family are concerned.

In European voluntary systems the benefits, as a rule, are entirely too low. An insurance system requires a careful balancing of income and outgo, of financial resources, and benefits payable. When required to carry the entire burden or when, as in Denmark, receiving only a small subsidy, the insured workman is unable to provide the cost of liberal benefits. In Denmark the actual amount is left to the discretion of the fund, with a minimum limit of

40 öre (11 cents) per day, and a maximum of two-thirds of the wages. As a matter of fact over 70 per cent were granting only 40 to 60 öre (11 to 16 cents) and only 12 per cent 1 krone (26.8 cents) or a little over. This sufficiently measures the limited efficiency of voluntary systems. The British scale is pretty well known (10*s.* for men and 7*s.* 6*d.* for women, per week, with somewhat reduced rates for certain groups). In view of the actuarial rigidity of the British law, there are various other reductions to be made under all sorts of conditions which may influence the actuarial solvency of the funds, for, since the scale of contributions is rigid, adjustment, according to the law, must eventually be made through reduction in the benefit scale. Even if the actuarial basis of the system could prove accurate on the average, it was inevitable that shortages would be discovered, so that benefits may be reduced in many societies. This aspect of the situation will require a separate discussion in due place.

Where benefits are adjusted in proportion to wages, the usual amount is one-half of the wages, as in Germany, though not the actual wage of the sick, but an average or basic group wage, is meant. Different basic wages for groups of insured of the same fund may be provided, but the basic wage must not exceed 5 marks (\$1.19) per diem. The maximum normal sick benefit therefore is 60 cents per diem, or \$3.60 a week.

The same 50 per cent scale is found in most other

compulsory acts, as those of Hungary, Russia, Luxemburg, Servia, and Roumania, the latter, however, trying to adjust the amount to economic needs by cutting it down to 85 per cent for single workers.

There is a curious tradition that in matters of social legislation we need not go above the minimum which European experience indicates. It is well known what pernicious influence the highly unsatisfactory British compensation act has exercised upon American legislation. The minimum German scale of 50 per cent should not, however, be accepted as the final word of Europe. Both Austria and Norway have made it 60 per cent. Finally the most recent act of Holland has established a 70 per cent scale. In Germany permission is given by the law to increase the benefit up to 75 per cent. Some 10 per cent of the German funds, representing a very much larger proportion of the membership, have increased it to 66 2-3 per cent, and perhaps some 2 per cent even to a larger amount up to the legally permissible limit. There is, therefore, a strong feeling that 50 per cent is insufficient, and that the rate of sick benefits should be raised to the level of accident compensation. In the brief experience of American compensation enough evidence has already accumulated to prove that 50 per cent is insufficient to prevent poverty and an appeal to charitable relief.*

* See *Three Years Under the New Jersey Workmen's Compensation Law*. Report of an investigation under the direc-

It must be quite evident that as far as the economic problem concerned is created it makes very little difference to the workman or his dependents whether his disability is due to illness or an accidental injury, or, to carry the point further, whether it is due to an industrial or non-industrial accident, the former calling for compensation and the latter for a sick benefit. And while 50 per cent of the wages still remains the predominating scale of the American compensation acts (22 acts out of 34), it equals 55 per cent in Indiana, 60 per cent in Hawaii and Texas, 65 per cent in California and Wisconsin, and 66 2-3 per cent in Massachusetts, New York, and Ohio. Substantially the "two-thirds" scale has been recognized in 5 states; the most significant feature being the change from 50 per cent to 66 2-3 per cent in Massachusetts in 1914, after only two years' experimentation with the 50 per cent scale, which was thus definitely pronounced inadequate.

It is true that on certain wage levels a two-thirds scale would be palpably insufficient. Without going here into tedious data on wage statistics, the growing movement for minimum wage legislation is sufficient evidence that in many industries, especially those employing female labor, the wages are insufficient to provide even the minimum physiological standard. Very likely for many members of these

tion of the Social Insurance Committee of the American Association for Labor Legislation, New York, 1915; especially pp. 37-42.

wage groups two-thirds benefit may prove rather meager. The customary provisions for minimum benefits (usually \$5 or \$6 a week, occasionally \$4, or full wages when they do not reach even the level of minimum benefits) which are so common in American compensation acts represent a distinct contribution to the theory and practice of compensation. There is no reason why, on the whole, these provisions as to the minimum amounts should not be carried over into health-insurance acts.

And yet, at the chance of appearing somewhat too conservative in this matter, the writer feels constrained to suggest that a little greater care must be exercised in applying these minima. The one possible objection to such minima is the possibility of the compensation or sick benefit equaling the normal wage or so nearly approaching it that an unnecessary stimulus to malingering or simulation, or at least what has been called valitudinarianism (or unconscious exaggeration of ailments), may be created. While this danger is usually exaggerated with malicious intent to injure the social-insurance movement, it cannot honestly be altogether denied. In case of accidental injuries (whether due to industrial or non-industrial causes) there are usually objective facts, by observation of which these tendencies may be overcome. In health insurance the problem is somewhat more difficult to meet. Instead of a flat minimum of \$5, \$6, or even \$6.50, it may be more desirable to provide a sliding scale, which will

leave some margin between the wages and the sick benefit and thus some economic motives for termination of the disability period. Of course a rational sliding scale is difficult to construct. All such scales must be somewhat arbitrary. The following scale is offered, not as an ironclad standard, but rather as a basis of discussion and an illustration of the principle involved:

Weekly Wage	Normal Rate	Normal Benefit	Suggested Rate	Resulting Benefit
\$10	66 $\frac{2}{3}$ p. c.	\$6.67	66 $\frac{2}{3}$ p. c.	\$6.67
9	66 $\frac{2}{3}$ "	6.00	66 $\frac{2}{3}$ "	6.00
8	66 $\frac{2}{3}$ "	5.33	70 $\frac{2}{3}$ "	5.60
7	66 $\frac{2}{3}$ "	4.67	75 $\frac{2}{3}$ "	5.25
6	66 $\frac{2}{3}$ "	4.00	80 $\frac{2}{3}$ "	4.80
5	66 $\frac{2}{3}$ "	3.33	85 $\frac{2}{3}$ "	4.25
4	66 $\frac{2}{3}$ "	2.67	90 $\frac{2}{3}$ "	3.60
Under 4	66 $\frac{2}{3}$ under	2.67	100 $\frac{2}{3}$ "	full wages

The principle of a maximum provision is more easily disposed of. Such provision is found in almost all American compensation acts; the usual levels are \$10 or \$12—only seldom do they fall to \$8 (Colorado) or rise to \$15 (Kansas, Texas) or even higher. The argument for such limitations is purely financial, to save cost to the employer. It has nothing whatever to do with the social theory of compensation. With a scale of 66 2-3 per cent. a \$12 maximum hits every worker earning above \$18; a \$10 maximum hits even every one earning over \$15. Such narrow limits are altogether undesirable. Since

both the benefits and contributions are based upon a percentage of earnings, the limits are unfair to the members of these higher-wage groups. But a much better and logical basis for a maximum limit exists. We have argued (on page 38) that clerical employees earning over \$1,200 a year (or approximately \$23 a week) may be excluded from the operations of the compulsory system. Thus no clerical employee would receive more than \$15.33 a week in sick benefits. No such limitations were established for the manual wage-workers, mainly because of the fluctuations and irregularity of the wage-worker's earnings. But with very good logic a uniform maximum sick benefit of \$15 may be embodied in the act.

DURATION OF BENEFITS

How long should sick benefits be payable? The somewhat artificial but necessary line of demarcation between sickness and invalidity insurance has already been indicated. Just at what point the line is to be drawn must be decided upon somewhat arbitrarily. In Denmark, recognized funds are required to grant sick benefits for at least 13 weeks within one year. No maximum is prescribed by the law. In actual practice, some 60 per cent have retained the required minimum, about 25 per cent have increased it to various periods under 26 weeks, and the remaining 15 per cent have made it just 26 weeks. Prac-

tically no funds (with one or two exceptions) have gone beyond this limit.

In Germany, the original minimum period was 13 weeks, but was raised by the act of 1903 to 26 weeks. The local funds have the right to increase this period to 52 weeks, and may, in addition, provide for treatment of convalescents for another year. The German experience indicates that, with a healthy democratic organization of sickness funds, voluntary extension of the minimum limit is not at all rare, but nevertheless the legal requirement determines the predominating type. In 1885, 80 per cent of the funds kept to the minimum limit, and by 1903 about 75 per cent, several thousand funds increasing the time to longer periods up to 26 weeks. Since the raising of the legal requirement less than 1,000 funds pay for from 26 to 52 weeks, these being largely establishment funds.

In Great Britain the line of demarcation between "sickness" and "disablement" (invalidity) benefits is drawn at the conclusion of 26 weeks.

In Austria and Hungary the limit is somewhat shorter,—20 weeks,—though a further extension of this minimum requirement has been discussed for nearly 10 years. Both in Norway and in Russia the same 26 weeks' limit prevails. Only in Roumania it is shorter—16 weeks only. European experience, therefore, places a certain stamp of official approval upon this dividing line.

There is no mysterious significance attached to

the half-year period. But the only logical basis for determining the proper limit is the separation of cases of illness from those of chronic invalidity. A 13 weeks' period, according to available data, would leave some 3 1-2 per cent of the cases without aid perhaps at the time when such aid is most important. The number of cases extending beyond 26 weeks is only 6 per 1,000, and includes little besides cases of chronic invalidity.

On the other hand, the extension of time from 13 to 26 weeks can be granted at a comparatively slight cost. An analysis of statistics of the Leipzig fund (perhaps the best available and covering almost 90,000 cases of illness per annum) seems to indicate that the additional number of sick days which become compensable because of an extension from 13 to 26 weeks constitutes only a little over 5 per cent of the total. Protracted illness may require a higher expenditure for expert medical aid, hospitals, convalescent homes, etc. In any case the additional loading must represent very much less than 10 per cent.

WAITING PERIODS

A time limitation, of a somewhat different kind, is usually established also for the beginning of the case of illness, known technically in compensation legislation as a waiting period. With the natural tendency to draw upon compensation experience in

shaping insurance standards, the question may become more acute than it ever did in Europe. To prevent administrative difficulties out of proportion to the economic loss of very brief periods of illness, and also to prevent a certain form of malingering, due to occasional debauch, a brief waiting period is advisable, during which money benefits (but not medical aid) may be denied. In Germany the law establishes a 3 days' period, though the local funds may shorten or remove it altogether. The period is also placed at 3 days in Great Britain, while in Denmark the voluntary funds are permitted (but not required) to have a waiting period up to 7 days. Unfortunately, in American compensation acts a longer waiting period (7 days in a few acts and 14 days in most) has become the rule. A similar tendency in sickness-insurance acts is certain to appear. It should be energetically contested.

The majority of cases of illness would fall within so long a period, and denial of benefits for all such cases would go far to discredit the entire system in the eyes of the workers.⁴ Moreover, there is this distinction between accidents and sickness, that repeated injuries to the same individual are exceptional while repeated attacks of short periods of illness are not at all rare. Numerous recent wage investigations have established beyond any doubt that the omission of even

⁴ According to the experience of the Leipzig sick fund in 1912, 47.4 per cent of all cases lasted less than 3 weeks, after excluding cases under 3 days.

one pay envelope may be a serious matter to thousands of workers, and an interval of 3 weeks between one pay day and another may often spell ruin to a family or call for charitable assistance. The watchword of social insurance should be "Not a week without a pay envelope." A 3 days' waiting period is all that the entire experience of sickness insurance justifies.

The same term "waiting period" is often used to define a different limitation, namely the requirement of a certain period of insurance before the right to benefits is acquired.

Under a voluntary insurance system this requirement may be advisable as a method of protecting the funds against unfavorable selection of risks. In Denmark, the determination of such a time limit is left to the various funds. Under a compulsory system such a waiting time is neither actuarially necessary nor socially just, since membership necessarily follows upon employment, and the average degree of health of persons actually employed cannot be influenced by any one individual's act. Nevertheless, the British act provides that no sickness benefits can be paid until the expiration of 26 weeks of paid-up insurance. It will be remembered that the actual payments of benefits did not begin until 6 months after the collection of contributions began, and in this way a substantial working capital was accumulated. As a temporary fiscal measure, this may have been justified, though some doubt may be entertained whether the advan-

tages derived proved a sufficient compensation for the amount of popular irritation created. The preservation of the same rule seems much less justified. However, since membership is compulsory and only one waiting period during the entire life of the insured is required, the regulation will affect only very young persons, and the amount of distress caused by this provision is probably small.

Finally, the German law specially prohibits any provision for a waiting period of this character, though in case of voluntary members a period not to exceed 6 weeks is permitted. Here again the German precedent is the one that should be followed.

Of course the possibility of imposing upon the health-insurance fund if not for feigned illness then at least for chronic disability or invalidity is not entirely eliminated by making insurance automatically follow employment. If insurance is thus made to lose all aspects of a voluntary act, employment does not. If insurance with all its benefits be made to follow employment no matter how short, and since 26 weeks of sick pay is one of the benefits, 2 weeks of work during the year might create the right to 52 weeks of sick benefits and thus invalidity insurance be smuggled into the system. Even a true invalid for whom regular employment is either impossible, or if possible, decidedly injurious, may make the extraordinary effort to return to work for a week or two if in this way all his benefit rights, already expired through time limits, might be renewed.

It becomes necessary, therefore, to establish other limitations of a somewhat involved nature, so as to prevent the abuse of the system by the clever and ingenious few. It is not only the financial loss, perhaps actuarially slight, that is involved. But nothing injures the popularity of any act of social legislation, especially in its initial stages, as does evidence that it permits abuses and invites deception.

The British rule in respect of this problem is rather complicated. Since the British system provides for both invalidity and sick benefits, the extent beyond the initial 26 weeks results (after the invalidity or "disablement" benefits were put into force) not in the discontinuance but only reduction of the weekly benefit. But suppose a short period of employment intervenes. Shall the following period of illness be compensated for as sickness (10s.) or disablement (5s.)? The rule established by the act demands that consecutive (even if interrupted) periods of disability be counted as one, unless a period of 50 weeks of actual employment and 50 contributions has intervened.

It is questionable whether this rule would always work out fairly to the insured. Suppose he were subject to short periods of illness interrupted by more or less prolonged periods of employment. If these periods were each much less than 50 weeks long, then sooner or later the 26 weeks would be exhausted, and subsequent benefits would be only at half the regular rate.

Surely there would be no justice in such an arbitrary limitation. Compare it with the extremely liberal provisions of the German Insurance Code on the same point. The organic provision establishes no limitation except that consecutive benefits in any one case are not paid for over 26 weeks (Article 183). By another provision (Article 188) the separate insurance carriers are only permitted (not required) to embody within their constitution a rule that after sick benefits are paid for 26 weeks (either successively or collectively during 12 months) the benefits for the next 12 months for a new case of illness shall be limited to 13 weeks. Even this mild restriction is inapplicable when the new case of illness has no connection at all with the old illness.

With such differences in standards to face us, the decision as to the right rule must be based upon a priori reasoning rather than precedent. The object of the rule is to prevent invalidity benefits to be paid under the disguise of sick benefits. It should not aim at the innocent sufferer who happened to be hit by two consecutive cases of illness in rapid succession. It only requires that the new case be compensated on the basis of a bona fide recovery and return to work after the earlier illness. A single rule that not over 26 weeks of money benefits be paid during any consecutive 12 months may produce the desirable results, though it may leave 6 months following the receipts of the maximum benefit practically without coverage. The German rule, that

this particular limitation may be entirely disregarded when the new case represents an entirely new illness and not a failure of the older one to recover, would seem to be worthy of emulation, as essentially fair. Private insurance, whether of persons or property, may well have the advantage of canceling risks with bad experience because its entire success often depends upon an efficient selection of superstandard risks, and because without this selective process it would fall a ready victim to adverse selection of substandard ones. But compulsory public insurance must waive the privilege of selection, just as it is free from any serious danger of adverse selection.

SICK BENEFITS IN CONNECTION WITH HOSPITAL CARE

It is not the intention of the writer to lumber up this discussion of broad essential standards with questions of detail and minor importance.

But it is important to discuss at this place at least briefly one or two aspects as yet not touched upon. Medical aid in our scheme is furnished in kind. The cash benefit is given to furnish food and other necessities. But suppose the patient, on account of the gravity of his situation, has been removed to a hospital, where, in addition to medical attendance and supplies, fuel and shelter are also provided? Shall the sick money benefit go on in the same way, even though perhaps not needed? And if it be discontinued how shall the needs of the family be met?

The argument is often made in favor of discontinuance that the cost of hospital attendance is usually higher than the combined cost of the sick benefit and ordinary medical aid. It is very doubtful whether this plea is at all correct if cases of sufficient gravity be compared, because a hospital may furnish the necessary variety of medical aid appliances and nursing very much cheaper than could be done in a private home. But the argument is altogether irrelevant actuarially, so long as the hospital benefit is granted as an additional benefit and not in substitution for other benefits.

The answer to the problem must be based primarily upon social considerations. What is needed in the cases concerned? And what are the results of this or that policy that may be expected? Obviously, the single man, without dependents, has no need of his full money benefit while staying in the hospital, perhaps has no urgent need of any sick benefit at all.

The case is very different if the patient has a family or other dependents. The sick benefit is intended to compensate them as well as the workman himself, and hospital care to the latter will not feed the hungry wife and children. In such cases the German law prescribes the payment of one-half the regular benefit (usually one-fourth of the wages) to the dependents directly. The bill of the American Association of Labor Legislation (known in New York as the Mills Bill) followed this standard, requiring the payment of a benefit equal to 33 1-3 per cent of the

wages. Criticism of this amount as utterly inadequate has already reached the writer, and the justice of the criticism must be admitted. Few wages there are, of which a third would provide even for the bare necessities of an average-sized family. Besides, not the cost of the ill workman's stay in a hospital, but rather the possible saving effected by the family on account of his absence, should be the basis of the reduction of the normal sick benefit to a lower level. Surely the married workman does not claim one-half of the normal expenditures of a normal family. Even one-fourth would be a fairly liberal estimate. And from this point of view a reduction of the sick benefit from 66 2-3 per cent to 50 per cent would be all that is justified.

There is, however, another circumstance to be taken into consideration. What is the possible indirect effect of any decision upon this point upon the willingness of the patient to go to a hospital? It is difficult, even somewhat cruel, to send him to the hospital against his wishes, though sometimes it may be absolutely necessary for his own good (serious operation) or the good of his neighbors (infectious disease). But it is undesirable to stimulate a tendency to go to the hospital when conditions do not call for it. It is an unnecessary expense. It may preoccupy necessary hospital space. Of course this should be regulated by special administrative measures. But the indirect effect of economic motive is difficult to counteract. If the family

may benefit financially by the transfer of the patient to the hospital, this will be done frequently. If, on the other hand, the removal to the hospital would mean a starvation allowance for the family, this will be resisted even while seriously needed. From this point of view the "one-half of regular benefit" provision may work extremely unfairly, and a reduction of only one-fourth or at most one-third (from 66 $\frac{2}{3}$ per cent to 44 $\frac{1}{3}$ per cent, or roughly 45 per cent) is very much more consistent. Again, here too a sliding scale may be constructed of 33 $\frac{1}{3}$ for the wife, without children or other dependents, and an additional 8 $\frac{1}{3}$ per cent for each additional dependent up to the maximum 50 per cent. The question is one of detail, to be sure. But it is upon a mass of such details that the success of every legislative act depends.

VII

MATERNITY BENEFIT

WITHIN recent years maternity insurance has acquired the dignity of a separate branch of social insurance. An enormous literature has grown up concerning it,¹ and the demands for it, especially from the radical branch of the modern woman's movement, are insistent. It is significant, for instance, that it was to represent one of the important questions to be taken up by the International Socialist Congress which was to gather at Vienna in August of 1914. And yet curiously enough, with two or three exceptions, maternity benefits in actual practice constitute one of the services of a compulsory health-insurance plan.

¹ The most exhaustive work on maternity insurance by Madame Alexandra Kollontai, which has recently appeared, is unfortunately written in Russian, and thus not available to the average American reader (*State Insurance of Motherhood*, being Vol. I of *Society and Motherhood*, in Russian. Petrograd, 1916, pp. 641). It also contains a splendid bibliography of Russian, German, English, French, Italian, and Finnish works. The writer is informed by Mrs. Kollontai that a German edition of the work, nearly ready, was interrupted by the war, but may eventually appear. See also the selected bibliography compiled by Dr. Lee K. Frankel ("Maternity Insurance," *New York Medical Journal*, Dec. 18, 1915).

The Italian method of handling its problem through an independent system and institution has been frequently described in American literature.² In addition France and Australia have established independent systems of maternity benefits, of which more will be stated presently. In none of these countries, however, does a general compulsory health-insurance system exist. But wherever both general compulsory sickness insurance and maternity insurance exist, they are found combined into one administrative system. Furthermore, it is also true that maternity benefits of some kind or other are given practically in connection with every existing system of compulsory health insurance. Besides the administrative advantages of such a combination of functions, the inherent relationship is quite obvious, at least as far as the short period of child-bearing is concerned. The question whether child-bearing, being a physiological process, should be properly classified with sickness is a somewhat academic one. It requires medical aid. It produces temporary disability. That is sufficient to put it into the category of emergencies that a health-insurance system should deal with.

But the fact that an independent campaign for maternity insurance exists and in some countries existed 10 or 20 years indicates specific economic causes which force this problem upon the civic body in industrial states.

² See Frankel's bibliography.

The function of maternity insurance may be analyzed under the following five headings, corresponding to the five causes of economic loss, connected with childbirth: (a) extraordinary expenditures for medical aid and supplies connected with childbirth; (b) the period of enforced idleness and the consequent loss of wages; (c) the necessary period of rest before childbirth, to preserve the health of the mother; (d) the equally necessary period of rest after childbirth, for the purpose of both strengthening the mother and improving the chances of the child; and (e) the assumed "right of the child to its mother," which right and need can only be satisfied by, at the least, temporary withdrawal of the working mother from regular remunerative employment. It is in the last, fifth function that the limits of health insurance, or at least sickness insurance, are crossed. For the period during which the newborn child may profit, first by breast feeding and subsequently by personal attendance of its mother, extends perhaps for years, and surely far beyond inevitable disability of the mother.

Thus maternity insurance, or perhaps its broader form, motherhood insurance, may, theoretically, merge into state endowment of motherhood. It is from this broader point of view that maternity insurance is advocated by the radical feminists of Europe, as a transitory step to a much more comprehensive system of prolonged motherhood pensions. State endowment of motherhood

is advanced not only as a measure of economic necessity for prevention of destitution, but also as a social measure "aiming at the emancipation of the child-bearing woman from her economic dependence upon man."³

At this place, however, it is unprofitable to enter into the discussion of that broad and fascinating problem. Maternity insurance is analyzed here only as an aspect of disability or sickness insurance, and if a technical distinction is desirable, such may readily be drawn between maternity insurance (covering the act of childbirth and the short periods of time immediately preceding and succeeding it—i. e., the disability more or less directly connected with child-bearing) and motherhood insurance, (covering the female function of child-rearing). The line of distinction is not hard and fast, it may be even called arbitrary, but this it shares with most artificial lines of distinction, such as for instance the distinction between sickness and invalidity drawn at the expiration of 26 weeks of disability.

But even within this narrower limitation, maternity benefits have several features distinct from ordinary health insurance, because the prophylactic factor is of greater importance and because the interests of the future generation are also directly concerned, for neglect within the first weeks or months of the infant's life is a strong factor of infant mortality.

There are three distinct aspects to the economic

³ See Kollontai, loc cit., p. 230.

problem confronting the mother in the wage-working class: (1) that of the married woman worker who combines the duty of a wage-earner with those of a housewife, or at least a wife, and is in most cases only partially dependent upon her earnings; (2) that of the unmarried wage-earning mother; (3) that of the wage-earner's wife who is "not gainfully employed" in the sense of not bringing any money revenue into the family treasury.

The distinction between the first and second aspects is largely a moral one, that between the first two and the third primarily an economic one. The moral problem involved should be easily disposed of.

Within the last decade a noticeable revolution has taken place in the moral viewpoint, if not the moral philosophy, of American society, which is at least bold enough to face sex problems frankly. The unmarried mother is in Europe a significant social fact, and numerically an important factor in its population. In Germany, for instance, some 180,000 children,—8 per cent of the total,—are annually born out of wedlock. As is to be expected, the wage-working woman, or at least the woman of the wage-working class, shows the highest rate of illegitimacy. Whether, as the radical feminist wing is ready to assert, this represents an active and powerful tendency for abolition of the "bourgeois" family and the assertion of the "free woman's right to motherhood," or is the result of the breakdown of moral standards due to poverty, ignorance, and overwork, as an

American social worker would insist, makes much less difference than the vital fact that these 180,000 women are mothers and that the "illegitimate babies" have a right to grow into healthy and useful citizens of their country.

Motherhood out of wedlock is by far not as frequent here as it is in Europe, but so long as it exists the economic consequences must be provided for. The social-insurance movement has or should have no official point of view on matters of sexual morality. The important thing is that the unmarried mother's health and her child's life must be taken care of. The economic need in her case is greatest. The only fair way of handling this problem is by entirely omitting in the act any reference to distinctions between legitimate and illegitimate births.

As between the employed, self-supporting woman and the dependent wife of a wage-worker, there are material economic differences. In most cases of the latter type economic losses resulting from enforced idleness are not so large or important, except possibly for the cost of hiring some help during a short period, when neighborly help is lacking, and the numerous purchases that must be made for the sake of the infant. Therefore, the main, pressing need is for medical aid and supplies, and this may be interpreted sufficiently broadly to include most of those extraordinary expenditures.

A careful study of the literature of maternity insurance, especially the literature in advocacy of the

measure, proves that the explanation of the movement must be looked for primarily in the recent development of female wage-labor. Maternity insurance forms a natural sequel to legislation prohibiting wage-work to women for some definite time before and after maternity.

The argument, repeated in hundreds of pamphlets and supported by a wealth of statistical and physiological data, though essentially obvious and scarcely calling for proof, is that—

1. Wage-work, calling for strenuous and protracted effort, is injurious to the prospective mother at least for some time before childbirth.

2. Anything which injures the health of the mother also injures the health of the child about to be born.

3. Breast feeding by a healthy mother is the most important factor preventing infant mortality, which even in civilized Germany reaches 15 per cent during the first year of the infant's life.

For the wife of a steadily employed working-man the problem of childbirth may not be so critical and tragic, at least in the majority of cases. But even within its narrower limitations, a real problem exists at least in some countries. To one who may be inclined to doubt it, the perusal may be recommended of a little book,⁴ recently published in England, containing 160 simple letters from working-men's wives,

⁴ *Maternity*. Letters from working-women collected by the Women's Coöperative Guild. London, 1915.

describing the horrible conditions of discomfort, want, mental anguish, ignorance, and neglect, under which to-day children are born in England, conditions leading to fearful infant mortality on one side and lifelong suffering and invalidism of mothers on the other.

How great the need for relief of these conditions is in Europe, the rapid development of maternity insurance demonstrates. But as to the actual methods and results there is a considerable variety in European practice. In fact, altogether 14 systems of maternity insurance may at present be recognized, and 10 of them are in connection with compulsory health-insurance systems (Germany, Austria, Hungary, Great Britain, Russia, Norway, Bosnia-Herzegovina, Servia, Roumania, Luxemburg). Italy has an independent system of compulsory maternity insurance, in Switzerland maternity insurance is a feature of the comprehensive but voluntary sickness-insurance system, and finally France and Australia have recently taken a new step in "social insurance" by providing non-contributing state pensions to lying-in women.

So far as our three selected types of legislation are concerned, very little has been accomplished in the voluntary system of Denmark. Lying-in benefits are not required by law, and as a rule are not given by the recognized societies beyond the medical aid necessary in case of unusual complications. Attendance by physicians at childbirth is not common in Euro-

pean countries. A few societies provide insured women with the service of a midwife.

In Germany a substantial lying-in benefit, amounting to a sickness benefit for 8 weeks, is required by law for all insured women, no distinction being made between married and unmarried mothers. With the consent of the lying-in woman, medical attendance, services of midwife, or nurse, or hospital care, may be substituted for the entire maternity benefit, or parts of it. Special pregnancy benefits, in case of incapacity up to 6 weeks, are among the optional benefits allowed by the sick fund, as also the extension of benefits to the wives of insured persons.

The maternity benefits of the British law have occasionally been referred to as the most liberal in Europe, but that is hardly correct. The basic maternity benefit is a flat amount of 30 shillings, but this is payable both to the insured women and to the wives of insured men. However, in Hungary, Servia, Roumania, and Norway as well, maternity benefits to wives of insured persons are compulsory. In addition to the 30 shillings, insured women are entitled also to the regular sickness benefit during confinement. The 30-shilling provision is entirely free from any moral strings; all wives (or widows in case of posthumous children) of insured persons, and all insured women are entitled to it. Curiously enough, however, the additional sickness benefit just referred to is payable only if the "insured woman" is married. Some discrimination against the unmarried mother

was after all dragged in to satisfy Anglo-Saxon moral standards.

Neither Germany nor Great Britain thus furnishes, at least in its laws (German practice being on the whole very much better than the minimum requirements of the law), the best that Europe can show in the development of this movement. Neither in Great Britain nor in Germany is proper medical, or rather obstetrical, aid required. Indeed, the British act specifically states that "medical benefit shall not include any right to medical treatment or attendance in respect of a confinement."

As a matter of fact, that is probably the main purpose to which the money benefit is applied. But is not this purpose sufficiently important to be achieved directly? Under the present system two results are often observed in England: the physician's fees have increased, and instead of a guinea, all the 30 shillings is charged frequently; or the woman in her ignorance may be tempted to save on medical aid, or on foods necessary to her, for the purpose of utilizing the ready cash for other purposes. Neither of the two results is socially desirable. Proper attendance at childbirth is a matter of primary importance to preserve the life and health of both mother and child. So long as the very existence of a health-insurance system presupposes some efficient and economic organization of medical aid,⁵ why, in this branch of medical service, shall all the faults of private bar-

⁵ See Chapter XIV, "Organization of Medical Aid."

gaining be left undisturbed? Maternity insurance is not meant to result mainly in a swelling of obstetricians' fees.

Nothing can be more readily estimated than the approximate number of births, and nothing can, therefore, be more easily provided for in advance. In Austria, in Hungary, in Russia, in fact in almost all the compulsory systems enumerated above, such medical aid is required. It should not be forgotten that annually in the United States some 15,000 women lose their lives from childbirth or various conditions connected therewith,* and that the number of those whose health is impaired because of unskilled aid is very much larger.

It seems scarcely necessary to argue that medical aid is needed for the wage-worker's wife, as well as for the woman who is a wage-worker herself. The problems which arise in England, as to whether the 30 shillings should be paid to the insured husband or his child-bearing wife, whether in a case of a dissipated husband the proper use will always be made of the 30 shillings, etc., could be easily avoided, if 30 shillings' worth of efficient expert obstetrical

* According to mortality statistics for 1913, 10,010 deaths occurred from various causes connected with the puerperal state (4,542 from puerperal septicemia, 2,397 from puerperal albuminuria, and 3,071 from other causes). The death registration area of the United States for 1913 contained the population of 63,298,718 or 65.1 per cent of the entire population. The total number of deaths from this cause may therefore be estimated at $10,010 \div .651 = 15,376$.

service and necessary supplies were furnished instead of money. For the woman who is self-supporting, the additional money benefit, no matter how designated, is equally necessary. The "twilight sleep" is still in its experimental stages, and even for the thoroughly healthy woman child-bearing means enforced incapacity to earn a living for many weeks at least.

As to the duration of these benefits laws again differ. The Italian law of 1911 establishing compulsory maternity benefit resulted from a labor law prohibiting employment of women within four weeks after childbirth. Of 12 countries granting maternity benefits the required period is 4 weeks in six, 6 weeks in five, 8 weeks in two (Germany and France). Somewhere between 4 and 8 weeks must, therefore, be the minimum period of enforced rest after childbirth.

Under normal conditions, 6 or even 4 weeks after birth should be sufficient as far as the mother's health is concerned. But while a good many prospective mothers may retain their perfect health until the last day before delivery, as a rule earning capacity stops some time earlier, nor is strenuous effort during the last few weeks quite safe to either the mother or the child. The German law permits at least 2 weeks' benefit before childbirth, the Russian act 2, and the French 4 weeks. These periods are included in the total period indicated above, but in several countries the law permits optional extension of benefits to pregnant women for longer periods.

Finally, the interests of the child would require at least some extension of time after the necessary period of recuperation for the mother. During this period breast feeding may be kept up, and some care given at the time when it is most important. In Germany, such extension up to 6 weeks is permitted. Altogether, the liberal and prosperous fund may grant aid for 14 weeks to the wage-working mother.

To underscore the importance of these measures for purposes of health conservation, some figures of our mortality statistics may again be quoted. Some 80,000 children in the United States die annually from diseases of early infancy, of which about two-thirds die from premature birth, and one-third from "congenital debility," inanition, debility, and marasmus, practically all preventable conditions.⁷ And while it would be idle to claim that in all or in the majority of the cases the lack of mother's care is the cause, yet recent investigations by the United States Children's Bureau leave no doubt as to the importance of its lack as a contributing cause. Of course the data prove that indiscriminating distribution of benefits alone will not solve the question of infant mortality, as the Webbs have so significantly pointed out. For this reason assistance in kind, by medical aid, by

⁷ The number of deaths in the registration area of the United States in 1913 from disease of early infancy was 52,865, which would be equivalent to about $52,865 \div .651 = 81,206$ for the entire country.

visiting nursing, etc., is of even greater importance. But it is statistically established that three months of breast feeding have a decided preventive effect upon the extent of child mortality.

Accepting the necessity of these provisions, the question of selection between a separate maternity-insurance system and maternity-insurance benefits as a part of a health insurance still remains. As was shown above, European precedents are almost without exception in favor of the latter system. Whatever the difference of underlying economic principle may be, the decisive point is that the services to be rendered—medical aid, nursing, supplies, weekly benefits for a limited time—are all identical in both systems, and the waste of duplicating the administrative machinery obvious. Moreover, unless a system of gratuitous state subsidies for maternity be the other alternative, a separate system would place a heavy burden upon the wage-working women; while the cost is easily diffused in a general health-insurance organization. Especially cumbersome would be the organization of a separate system in this country, where the number of married women at work is smaller, and motherhood out of wedlock less frequent than in Europe.

The practical conclusion, therefore, is: that maternity insurance should be made an essential part of sickness insurance, and that it should include: (a) sufficient medical aid, (b) at least a 2 weeks' period of rest before childbirth, (c) from 4 to 6 weeks' bene-

fit after childbirth for the sake of the mother, (*d*) an equal additional period for the sake of the child.

Lest this be considered a utopian program, it may be stated here that, notwithstanding all the financial pressure of the war, Germany by a decree of December 3, 1914, has voted 2,000,000 marks a month for the purpose of providing for the wives of men at the front the following benefits at childbirth: (1) 25 marks to meet the cost of childbirth; (2) 1 mark per diem (including Sundays and holidays) for 8 weeks, of which at least 6 must be after childbirth; (3) 10 marks for additional nursing and medical aid, if necessary; (4) in case of a breast-feeding mother, 1-2 mark per diem for 12 weeks, making a total benefit period of 20 weeks, and a total maximum cost of 133 marks, or \$31.65.

In explanation of these measures the decree states that "the enormous sacrifice of human life which war demands make it the imperative duty of the state to take proper care for the preservation and strengthening of the coming generation at the very moment of entrance into this world."

Of course it is rather pathetic that civilized Europe should have had to wait for a world war to realize the general social value in the preservation and strengthening of the coming generation. One can only hope that day is coming and is perhaps not so very far off when the child's life will be worth while even in absence of any efforts at systematic annihilation of the human race.

It is impossible to close this discussion of maternity insurance without referring, at least briefly, to the strenuous opposition that has already developed to any plan of maternity benefits or maternity insurance in this country. In so far as the objection to maternity benefits rests upon the same foundation as that to the entire scheme of health insurance, or to the whole program of social insurance for that matter, such as the charge of paternalism, the un-American character of the principle of compulsion, the additional burden upon industry, and what not—no special rebuttal at this place is called for. But the opposition to maternity benefits as such, especially when it comes from individuals or social groups otherwise always found on the side of protective labor and social legislation, cannot be waved aside without further consideration.

Up to the present, practical discussion of health-insurance plans centers about the proposals advanced by the Social Insurance Committee of the American Association of Labor Legislation. The tentative draft of an act published by the Committee in November, 1915, and again in December, 1915, contains a specific provision (section 15) for maternity benefits to consist of—

1. All necessary medical, surgical, and obstetrical aid, materials, and appliances which shall be given insured women and wives of insured men.

2. A weekly maternity benefit, payable to insured

women, equal to the regular sick benefit of the insured, for a period of 8 weeks, of which at least 6 shall be subsequent to delivery, on condition that the beneficiary abstain from gainful employment during the period of payment.

This provision was eliminated from the Mills Bill introduced in the New York legislature in January, 1916, and the identical bills introduced in the legislatures of Massachusetts and New Jersey—all prepared by the same committee. This action in eliminating maternity benefits altogether was taken by the committee rather unwillingly under pressure of an opposition which suddenly developed, with such an ardent worker for social legislation as Mrs. Florence Kelly as chief spokesman.

The main argument advanced is the fear of the maternity benefit proving a stimulus or even a bonus for wage-work of married women. It is argued that the married women in industry represent an aspect of pauperized European labor, which is contrary to American traditions; that everything must be done to resent the extension of this European tradition on American soil; that only the wives of negroes, non-English-speaking aliens, and defectives and delinquents work for wages in this country; that wage-earning by wives of white men is a matter of choice, not of family necessity; and that the maternity benefits, especially the cash benefit, will encourage rather than repress this undesirable tendency.

As was forcibly stated by one opponent: Offering a cash bonus amounts to saying to the wage-earning husband, "Send your wife into a mill, factory, or sweat-shop, and the public and the single women in her factory will send you a present for your next baby."

The objection is also raised that maternity insurance is a leap in the dark, because it is not based upon specific knowledge as to the number of married women in industry and their economic and social condition.

It is undoubtedly true that the wage-working married woman is a rarer phenomenon in the United States than in most European countries. It is also true that our statistical information concerning married women in industry is badly out of date, because the 13th census failed to utilize fully the extensive data collected at enormous cost.

But it does not follow that qualitative knowledge is necessarily worthless because it does not always possess sufficient quantitative accuracy. The number of married women at work increased from 515,124 in 1890 to 775,924 in 1900, or over 50 per cent. It constituted in 1890 14 per cent of all women at work, and in 1900, 15.5 per cent. The proportion of married women at work to the total number of married women in 1890 was 4.6 per cent, and in 1900, 5.6 per cent. What reason is there to assume that this tendency, accompanying as it does the industrial development of every civilized country,

has been interrupted in the United States since 1900?

Surely the general advance of women into industrial and commercial life has not been interrupted—that much we know. The number of women breadwinners registered as such by the census enumerators has increased from 5,007,069 in 1900 to 8,075,772 in 1910. The popular feminist and suffragist writer speaks with as much right of the demands of “eight million women,” as he (or rather she) did 10 years ago of the “five million.” It is likely that this increase has been exaggerated by change of method, but even after due allowance for this the number remains considerably in excess of seven millions (7,216,848),⁸ or an increase of some 44 per cent in 10 years.

It is also true that wage-work of married women is particularly common among the negro race. Yet it is not at all unknown among the native born, as is seen from the following data:

MARRIED FEMALE BREADWINNERS

	1890	Per cent	1900	Per cent	Increase per cent
Native White:					
Parents native	135,881	26.4	217,515	28.0	60
Parents foreign born .	36,875	7.1	69,065	8.9	90
Foreign born	72,617	14.1	102,416	13.2	41
Negro.....	269,169	52.2	376,114	48.5	40
Others.....	1,082	.2	10,764	1.4	876
Total.....	515,124	100.0	775,924	100.0	51

⁸ See “Recent Trend of Real Wages,” by I. M. Rubinow, *American Economic Review*, Dec., 1914, p. 815.

Comparatively, therefore, the predominating position of the negro race has considerably declined in the group of married women at work; and the native-born woman of native parentage is a more important factor numerically now than she was 10 years earlier. To be sure, this is only a superficial analysis. It should be further studied by localities and occupations; and the absence of corresponding data for 1910 is a serious handicap. But with all that the increase in the number of married women at work is a universal social phenomenon of no mean dimensions.

It is not necessary here to go into an analysis of the feminist argument demanding employment for married women as a means of self-expression, or the argument of the radical Socialist woman, welcoming the married woman into the rank of wage-workers, because she may thus become a comrade in the labor struggle, while the wage-worker's wife at home remains conservative and a drag upon the labor movement. It may be readily admitted that in the majority of cases wage-work of married women, as the wage-work of widows, is a phenomenon in social pathology, a result of insufficient wages, and much less frequently results from the desire to increase the family earnings, to provide for comforts, luxuries, or savings. The significant fact remains that hundreds of thousands of married women do work for wages even in this country and that their number is rapidly increasing; and if wage-work of the married

woman is injurious both for her and her children, surely it is doubly injurious both for mother and child during the period preceding and succeeding the act of childbirth. The purpose of maternity insurance is to prevent just this injurious effect.

Is the explanation for the woman's work always or largely to be found in the delinquency of her husband? If the wives of negroes and Italians predominate, is the main reason the unwillingness of the Italian or negro man to work for the support of his family? Such an explanation over-emphasizes the individual cause at the expense of broad economic and social factors. The disregard of the latter forces one to look for a multiplicity of specific causes in various countries. For there are no Italians and negroes in Belgium, Germany, or France, where wage-work of married women is common. The absence of Jewish married women in American industry is urged as a contrast, but it is forgotten that the Jewish worker is usually a skilled or semi-skilled worker, whose earnings are higher than those of the unskilled Italian subway digger, or negro elevator operator.

Moreover, the discussion on these lines leaves out of consideration the abandoned wife, the wife of the workman disabled by accident, acute illness, or chronic invalidity, the wife of the unemployed worker, who is driven to work at least temporarily, the mother of the posthumous child.

And finally the problem of the unmarried mother

need not be disregarded. There may be few of them in this country. The higher standard of sexual morality in American society may be admitted, though how far it could affect the millions of immigrant wage-workers, men and women, is problematical. The various reports of vice investigation commissions in Chicago, New York, Baltimore, Philadelphia, and elsewhere, somewhat disturb our American optimism in this respect. It is possible that the difference in illegitimacy is as much due to wider knowledge of contraceptive methods or greater frequency of abortion. And if the absence of systematized maternity benefits is partly responsible for it, by throwing the entire economic responsibility for the change in standards of sex morality upon the woman, isn't it about time to prevent this tendency from further extension?

There may be no exact measurement for the need of maternity aid. It is possible to overdo the demand for statistics and information as a preliminary to action. Most valuable social statistics, as a matter of fact, come as a consequence of constructive social action. We knew no more about industrial accidents when compensation legislation was advocated.

Statistical information concerning the extent of need created by motherhood is certainly lacking, and yet no experienced charity worker can fail to appreciate its existence. The writer was recently asked by a newspaper reporter how and when he first be-

came interested in social insurance. It was not easy to search through one's memory for the first stimulus which was responsible for 13 years of continuous and obstinate agitation in favor of social insurance before an indifferent public. But the impression received through a brief period of medical practice of the horrible circumstances under which some women of the wage-working class were forced to exercise their holy function of motherhood was perhaps more than anything else responsible.

The situation created by the elimination of the maternity benefits, as was done in the Mills Bill, is illogical and socially altogether untenable. The insured working-man is sure of medical aid and cash benefits, no matter what his illness. The working-woman who pays perhaps the same dues when totally disabled while exercising her important social function would be deprived of medical aid, of supplies, would have to skimp, worry, and perhaps go without the necessities—all because of a theoretical consideration that it would be better for her not to be a wage-worker, and for her husband to earn enough for both. Surely no one knows that better than the wage-working woman herself. It is significant that vigorous protests against the elimination of the maternity benefits are heard from the wage-working women, and their representatives.

In the Socialist press, Mrs. Anita C. Block, a well-known Socialist writer, calls upon the "Socialist

women to take the initiative and act without delay.”⁹ At a hearing before the Judiciary Committee of the New York Senate, at Albany, on March 14, 1916, Miss Pauline Newmann energetically protested in the name of the International Ladies’ Garment Makers’ Union. It would seem that the wage-workers themselves often more clearly perceive the inexorable tendencies of the age than even the most enthusiastic friends of social legislation.

⁹ *New York Call*, Magazine Section, Jan. 30, 1916.

VIII

FUNERAL BENEFIT

THERE is no necessary logical connection between sickness insurance and funeral benefits, especially when the term "health insurance" is used, but the historical connection is very close. Compulsory insurance grew out of voluntary insurance, as practised by mutual-aid societies, and help in funerals, both in kind and in money, was the earliest form of mutual aid. In many mutual-aid societies funeral benefits are given, but special funeral-aid societies are quite common in most European countries and in the United States.

This is true of Denmark, where sick-benefit societies do not grant funeral benefits. These are usually provided by formally independent burial clubs, but these are connected with, and under the same management as, sick-benefit societies. The separation is largely the result of the requirements of the law. The reason for such enforced separation is found in the possible actuarial dangers of an increasing death-rate among those voluntarily insured. Technically, funeral insurance approaches life insurance (since payments depend upon the contingency of death), and unless rates are scientifically built

upon a mortality table, the difficulties of assessment in life insurance may arise. The state has established a reinsurance fund for these burial clubs, and the permitted amount of insurance is light—150 kronen (about \$40)—while as a matter of fact about 85 per cent of them grant funeral benefits of only 100 kronen (\$27) or less. The British health insurance makes no provision at all for funeral benefits, for the same reason that may have a decisive influence in this country—i.e., the popularity of so-called industrial life insurance, which furnishes little besides funeral benefits but has succeeded in reaching practically the entire wage-working population—and the definite objections raised by the British industrial life-insurance companies against the inclusion of funeral benefits.¹

In Germany, on the other hand, funeral benefits on the death of insured persons are compulsory. The normal amount is small, 20 times the basic daily wage, and thus limited to 100 marks as a maximum. Voluntarily, the funds may increase it to 40 times the daily wage (maximum 200 marks), or establish a minimum of 50 marks (\$12). In addition, funeral benefits at the death of members of families are optional. In case of the death of wife or husband, they must not exceed two-thirds, and in case of children, one-half, of the normal amount. Funeral benefits of an equally modest amount are also granted by

¹ See *New Statesman*, March 13, 1915, Special Supplement, p. 30.

all other compulsory sickness-insurance systems, except that of Great Britain. What shall the attitude toward funeral benefits be in drafting American health-insurance acts?

It may be admitted that there is no such urgency about this form of benefit as there undoubtedly is about the other main branches of activity outlined above. Perhaps 80 per cent of the wage-workers, and a goodly proportion of the members of their families, are already protected by this, the least important, form of working-men's insurance. The preservation of a high standard of funerals, moreover, does not constitute the aim of social insurance. Besides, not to mince matters, the effort to introduce funeral benefits into a compulsory sickness-insurance system will undoubtedly create a very strong opposition from industrial life-insurance interests to the entire system proposed. It may be good politics, as it was in Great Britain, to yield without a fight—and keep these benefits out. But do these considerations entirely settle the matter? It would be out of place in this study to go into a detailed discussion of industrial life insurance as such.² But whether the high cost of life insurance to wage-workers can be reduced through a better system or not, it is evidently undesirable that a system which costs the American working-men some \$200,000,000 per annum should

² The writer has already done so in his work on *Social Insurance*, chap. xxv, "Life Insurance for Workmen," especially pp. 417-21. See also *New Statesman*, March 13, 1915.

result in no larger gain than an extravagant funeral. Even if industrial life insurance should remain as it is, anything that would prevent the established extravagance in funerals, and preserve the benefits of industrial life insurance for a purpose commensurate with its cost, would appear desirable. Extravagance at funerals among the poor has grown to be a serious economic problem, and as yet all efforts to overcome it have been unsuccessful. The assumption of this burden by the sickness-benefit fund would establish one fairly uniform standard, the acceptance of which would not mean loss of social caste, and finally, through democratic co-operative effort, it could cut down by probably more than half the altogether useless waste from overcharge and extortion of undertakers and cemetery-owners.

Compensation acts in various states have already established a standard of \$100 for funerals. If all the burials among the workers of a large city were handled by their own organization, and in their own cemetery, the cost could probably be reduced to \$50. And insurance for a burial benefit of that amount, with an average death-rate from 16 to 20 per 1,000, should cost from 80 cents to \$1 per capita per annum—about 2 cents a week.

It is evidently highly desirable that the advantages of co-operative effort be utilized in that direction. Only in this way lies a reasonable hope that life insurance for wage-workers might be forced into legitimate channels. That there is an earnest need

for such life insurance goes without saying. Nor can the high efficiency of large life insurance companies be altogether disregarded. But the social objection to industrial life insurance as at present conducted can never be overcome until some cheaper substitute for the present method of soliciting and collecting can be discovered. The method is a natural consequence of insuring for very small amounts, only sufficient for a funeral—of insuring all the members of the family down to the newborn child, and weekly premium so low that its collection by visitation becomes an economic absurdity. With the funeral problem out of the way, it is doubtful whether industrial life companies will be able to keep up their prodigious premium volume, unless some more effective system is substituted. And it is almost certain that with the ingenuity characterizing the management of this business, some such a system will be introduced. Perhaps the solution lies in some form of group insurance for which the health-insurance organization will offer a convenient medium.

IX

OPTIONAL BENEFITS

THE four main branches of effective service which a health-insurance system should furnish—medical care, sick benefits, maternity benefits, funeral benefits—have been outlined in the pages preceding. Throughout the discussion, it is hoped, a spirit of moderation in demands has been preserved, but the main conditions stated which must be created in order to realize the objects of modern health insurance. Though the system is compulsory, it should not be understood to place any limits upon the spirit of mutual aid and co-operation to which the organization of local health-benefit funds should prove a valuable stimulus. As in Germany, so in this country, voluntary extension of benefits may be expected. All such extensions should take place under proper control, so as not to result in financial embarrassment, nor in encouragement of malingering. Perhaps in the early drafts of the laws, which must deal with the difficulties of organization, the inclusion of detailed provisions for such optional benefits is not particularly important. In fact, the objection may be raised that they would give (as do the additional

benefits in the British National Health act) an appearance that some very desirable things are being accomplished, when as a matter of fact for some years to come all these additional benefits may remain dead letters. With the comparative ease of legislation in this country, it may be sufficient to provide for the immediate future.

Nevertheless a brief discussion of such optional benefits at this place may be useful for several reasons:

1. The list of optional benefits permitted clearly indicates how much necessarily remains undone even after the minimum requirements have been complied with. Presumably no law would include in its list of optional benefits such services as are evidently unnecessary. The insurance system should not furnish any luxuries entirely beyond the normal wage-worker's standard of living unless the conditions of illness makes necessities of such luxuries. The dangers of over-insurance are evident, especially when dealing with a condition as easily simulated as sickness, nor is there any reason why public funds, which may be needed at some other time for necessities, should be thus uselessly dissipated.

2. Most optional benefits have to some extent been realized at least in Germany. The actual achievements of the health-insurance system in Germany, and its possibilities in this country, cannot fully be realized without a study of these optional benefits.

3. The introduction of optional benefits depends largely upon the system of organization of the health insurance. It will thrive best under conditions of reasonable local autonomy, a healthy co-operative spirit, and democratic administration. It offers, therefore, an additional weighty argument for the particular system outlined in a subsequent chapter.

4. After the effective realization of the minimum standards, further extension of the system may be expected through gradual inclusion of optional benefits among compulsory requirements. A list of comprehensive optional requirements, therefore, outlines the lines of later growth while offering meanwhile numerous experimental laboratories for testing out the comparative value and popularity of various services.

It will be sufficient to study the optional benefits under two acts, the British and the German.

The optional or additional benefits of the British acts are 14 in number, and may be classified into four groups:¹

1. Increase of compulsory benefits.

- (a) Increase of the sickness benefit for all members, or only some, depending upon the number of dependent children.
- (b) Reduction or entire abolition of the three days' waiting period.
- (c) Increase of maternity benefit.

¹ Section 8 (1), Fourth Schedule, Part VI.

2. New benefits.

- (a) Payment of part or whole of cost of dental treatment.
- (b) Invalidity benefit to members only partially disabled.
- (c) Allowance during convalescence.
- (d) Old-age pensions in addition to those under act of 1908, or otherwise.
- (e) Payment of contributions to superannuation funds for benefit of members.
- (f) Payments to members in want.
- (g) Small money benefits to members in hospitals.
- (h) Payments to members not allowed to work on account of infection.
- (i) Refunding of contributions.

3. Extension of benefits to dependents:

Medical treatment and attendance for dependents.

4. Extension of activities.

The building or leasing of premises suitable for convalescent homes, and the maintenance of such homes.

In the German act the optional benefits are scattered through many paragraphs, in which the minimum benefits are outlined. Altogether some twenty such specific extensions may be enumerated, which for comparative purposes may be grouped into the same subdivisions:

1. Increase of compulsory benefits.

- (a) Increase of sick benefits up to 75 per cent of wages.

- (b) Grant for Sundays and holidays.
- (c) Sick benefits extended to 52 weeks.
- (d) Waiting period reduced or abolished in all cases, or only in cases of industrial accidents, or in cases lasting over one week.
- (e) Increased benefit payable to family when insured receives hospital treatment—from one-half to the full amount of the sick benefit.
- (f) Increased funeral benefit, up to 40 times the daily wage.
- (g) Minimum for funeral benefits increased to 50 marks (\$11.90).

2. New benefits.

- (a) Hospital treatment.
- (b) Nurses' attendance.
- (c) Appliances to prevent disfigurement or deformity.
- (d) Grant of special diets.
- (e) Grant of other therapeutic means.
- (f) Sick benefits (up to one-half of the regular sick benefit) to insured persons under treatment in hospitals.
- (g) Pregnancy benefits up to 6 weeks.
- (h) Medical treatment for ailments due to pregnancy.
- (i) Nursing benefits (or motherhood benefits) up to 12 weeks after confinement.
- (j) Convalescent care up to one year after illness.

3. Extension of benefits to dependents.

- (a) Medical treatment to dependent family.
- (b) Maternity benefit to wife of insured.
- (c) Funeral benefits for death of consort or child.

The influence of the German list upon that contained in the British act is thus obvious. In practical effects they differ materially, because of the difference in financial organization of the two systems. Under the British act, the income is fixed, as explained in a subsequent chapter, while the outgo is often a matter of conjecture. The list of additional benefits simply means: "These are the things that may be granted, if any resources remain after the compulsory benefits have been complied with." Since the actuarial complications of the British system are such that it would be difficult to prove the existence of a surplus, and since as a matter of fact, in a great many insurance organizations the expenditures appear higher than was expected, the additional benefits appear a dead letter.

The optional benefits in Germany bear an entirely different character. They are functions which a democratic co-operative organization may assume if it is willing to bear the additional cost; and though this means an additional burden upon the employer as well as the beneficiary numerous sick-insurance funds have assumed many of such functions. As a brilliant example of such voluntary extension the famous Leipzig fund may again be referred to. It grants hospital treatment, nurses' attendance, special appliances, special diets, special methods of treatment, such as baths and massage, extension of sick benefits from 26 to 34 weeks, pregnancy benefits, care of convalescents in special institutions, medical, hos-

pital, obstetrical, and funeral benefits to members of family—i.e., almost all the optional benefits permitted by the law.

It will be observed that several of the so-called "optional" benefits of the German act are of such importance to the entire scheme of health insurance that they have here been included with the necessary minimum requirements. If the reduction of these standards should become necessary anything omitted from the required benefits should at least be re-established in the list of optional benefits. Even outside of that, several lines of desirable extension may be indicated:

1. Increase of various money benefits
 - (a) in time,
 - (b) in weekly amounts.
2. Further extension of care of injured and sick in
 - (a) convalescent homes,
 - (b) in special institutions for application of expensive methods of cure and re-establishment of earning capacity.
3. Extension of care and, possibly, small sick benefits to dependents, and, finally,
4. While it is undesirable to introduce extraneous functions into these specialized "health-insurance carriers," an extension of educational activities in matters of personal, public, and industrial hygiene, and establishment of institutions for prevention of illness, such as baths, gymnasias, would be desirable.

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When the question of organization is discussed it will appear what an important function in the general movement for preservation of life and health these new insurance-carriers may be made to fulfil.

X

BEARING THE COST

IN the preceding chapters all the necessary benefits of a comprehensive health-insurance system were discussed in some detail. Since insurance in the final analysis is but a mechanism of distribution, and not of itself productive, the income side of the ledger must at least balance with the expenditures. Yet nothing at all was said of the source of revenues out of which all these benefits were to be paid, and the services rendered. The plan, as developed until now, may invite the criticism that it is thoroughly utopian. Granted that all the benefits and services are desirable, so are a great many things. But are they also possible? Can the beneficiaries pay for all?

The technical defense to this criticism can easily be made. In all computations of insurance rates, the value of the benefits must be first ascertained. The computation for life-insurance premiums proceeds upon the assumption of a definite amount of insurance and the present value of this insurance payable at some unknown distant date, with due consideration to the effects of compound interest and mortality.

In computing insurance rates for workmen's compensation each particular act, with its various bene-

fits, must be separately valued. It was, therefore, the logical procedure first to agree as to necessary benefits, before the discussion should turn to the question of cost. Nothing was included in those benefits which did not appear absolutely necessary for the health and efficiency of the present and future generations of wage-workers.

Nevertheless it must be admitted that the list of included benefits is comprehensive, and without making at this time any definite statements as to the probable cost, it appears more than likely that, taking these benefits together, it is higher than the wage-workers as a class can pay for. That supposition is strengthened by the fact that only a small proportion of the wage-workers have voluntarily provided themselves and their families with health insurance, and that those who have organized into mutual associations for that purpose seldom receive more than a small part of all the benefits included as necessary here. The difficulty can be met in one way only: a considerable part of the cost must be shifted upon some other social group. Compulsory health insurance to be successful must be subsidized. If this term is objectionable, we may say that, in view of the social importance of health insurance, society must be required to contribute to its cost.

In the matter of distribution of the cost there are found perhaps the most important differences between the various types of insurance here studied. Under the purely voluntary system almost the entire cost

falls upon the insured workmen themselves. The word "almost" is used advisedly. Establishment funds (frequently known as aid or benefit societies) are a common form of voluntary health insurance. Few of them exist without any contributions from the employer, whether regulated by the very constitution of the funds, or in form of voluntary, charitable gifts. In those countries where voluntary insurance through mutual-aid societies has achieved a substantial degree of development (as, for instance, in France or Italy), honorary membership (limited to contributions without right to benefits) serves the same purpose. In France, there are nearly 500,000 honorary members in addition to the 3,000,000 participating members of approved mutual-aid societies, and the contributions of the honorary members constitute about 12 per cent of the total income.

Subsidized voluntary insurance introduces the element of a governmental subsidy, whether from the central or local government. In Denmark the state contributes one-fifth of the total annual dues, and in addition a per capita subsidy of 2 kronen (53.6 cents) per member. As shown by the statistical data, these two grants together amount to about one-third of the total revenue of the sickness-insurance funds. The narrow limits of the benefits granted by the Danish system seem to indicate that a higher subsidy might improve the social results materially.

All compulsory health-insurance systems (with the exception of those of Roumania and Holland) carry,

together with the compulsion of the employees to insure, also the compulsion of the employers to contribute to the cost, though the amount of the employers' contribution is subject to variation. In Germany the employer contributes a sum equal to one-half of the employee's contribution, or one-third of the total. The same is true of Austria, Russia, and some other countries. In the insurance systems of Hungary and Servia, employer and employee contribute equal amounts.

One of the important deviations of the British system from the German is the compulsory contribution from the public treasury, in addition to that of the employer. This is sometimes referred to as a distinctive feature added by Great Britain to the theory and practise of social insurance, but the claim is erroneous, not only because of the time-honored precedent of a state contribution in the voluntary system of Denmark, but also because of the inclusion of contributions both from the state and from the communal treasury in Norway's compulsory sickness-insurance law of 1909. (The proportions in Norway are: insured, 60 per cent; employer, 10; commune, 10; state, 20.)

The respective shares in the British law are so well known that it seems scarcely necessary to quote them: the insured pays 4*d.* (females, 3*d.*) per week, the employer 3*d.*, and the state, in a somewhat indirect way, 2*d.* In proportion to one another, the respective shares, in case of the male insured, are:

employee, 44.5 per cent; employer, 33.3 per cent; the state, 22.2 per cent; in case of the female insured the proportions are 37.5 per cent, 37.5 per cent, and 25 per cent. There are numerous modifying conditions, some of which will be referred to presently.

The propriety of substantial contributions from both the employer and the state is, therefore, supported by the whole history of the European experience. This results from the very philosophy of the social-insurance movement. But it is quite certain that the effort to establish in this country either sort of contribution will call forth a variety of objections and protests: from the employers, who must resent the specific tax upon their industry, and from the taxpayers at large, who regard it as a new and uncalled-for burden. In the struggle for the introduction of health insurance the demand for such contributions must be based upon specific arguments.

EMPLOYER'S CONTRIBUTION

Why should the employers contribute? We may give a sevenfold answer to that question.

1. The employer's contribution is but a fiscal method of charging the industry (in the final incidence partly the product and partly profits) with a part of the cost of insurance. Such charge is just, largely because it is needed in order to keep the benefits up to the necessary standards.

2. It is just, because the industry is responsible

for a large share of the illness existing among the wage-workers. In a great many branches of industry partial responsibility for the disease is quite obvious. Even outside of such clear cases, the marked fluctuation of the sickness rate in dependence upon the industry is a strong indication of such causal connection. Since the justice of this argument is admitted in application to industrial accidents, it cannot logically be denied, at least within certain limits, in the case of illness.

3. The employer's contribution may be defended from the point of view of the probable, or even almost certain, reaction upon the employer's profits, because of the obvious material gain to industry from improvement of health conditions which must result from an efficient system of health insurance.

4. In most European countries a further justification may be found in the fact that the burden of care of industrial accidents for a certain limited period (e.g., 4 weeks in Austria, 10 in Hungary, 13 in Germany) is assumed by the sickness-insurance system. This argument must be used with caution because at best it explains only a smaller part of the employer's contribution. In Germany, for instance, only from 8 to 10 per cent of the expenditures of the sickness funds is required to meet this cost, while the employer's contribution equals 33.3 per cent. The proportion must be still smaller in Austria, where care is given by the sickness funds to cases of accidents for 4 weeks only, and in Hungary, where

the employer's contribution is 50 per cent, and accidents are taken care of for 10 weeks.

5. The employer's contribution may be justified as a modification of the minimum-wage principle. In calculations of the required minimum wage, some allowance must be (and usually is) made for expenses connected with an average amount of illness. Evidently such provision can be much more efficiently made through the mechanism of compulsory insurance. It is true that as yet minimum-wage legislation in this country applies to women and children only, but whatever the constitutional difficulties, the principle is equally applicable to underpaid adult male workers as well. Wage-workers with an earning capacity considerably above the minimum naturally do not claim the protection of the minimum-wage legislation. This raises an interesting problem which will be discussed presently.

6. The compensation movement which has swept the country offers an additional argument for such a contribution. It was argued from the very beginning that by placing upon industry a direct financial responsibility for the occurrence of industrial accidents, a strong factor for prevention would be created. Though the history of compensation in this country is brief, the expectation has been fully realized. The "Safety First" movement is largely due to agitation in favor of compensation; progressive private employers vie with insurance-carriers of all types in developing the work of accident prevention.

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As to the results of this work statistical evidence is as yet lacking. But to doubt that such results must manifest themselves sooner or later would be to admit that the alarming accident frequency of this country is inevitable and incurable—a conclusion no safety engineer would for a moment countenance.

7. Finally, the compulsory contribution is only an extension, over all employers, of an obligation which an increasing proportion of the progressive employers are recognizing voluntarily. Without such compulsion society places a constant premium upon failure to provide for the health and safety of the employees. The movement which has developed under the flag of consumers' leagues stands as a recognition of the necessity of compulsion—which it endeavors to apply by means of "direct action" as opposed to the "political action" of a health-insurance law.

STATE CONTRIBUTION

The arguments in favor of a substantial contribution from public sources (whether the entire state or the individual community) are even stronger.

1. The responsibility of the organized state for a considerable share of preventable sickness through failure to enforce or provide satisfactory conditions of public hygiene is even clearer than that of any industry, because of the potential control over gen-

eral sanitation, housing, industrial activity, and education.

2. Society has a direct interest and concern in improving the health conditions of the wage-worker and in assisting him to resist the attacks of illness, because the health conditions of all classes of the population must improve or deteriorate together. The justice of the state contributing to the care and support of the sick through hospitals, sanatoria, medical inspection, visiting-nurse service, etc., is so well recognized that it does not seem necessary to press this argument further. But these services are open to all classes of the population, while compulsory health insurance as here outlined may seem to create a special class favoritism. The answer to this objection, however, is that while, theoretically, hospital service, etc., is intended for the entire population, in actual practice it is utilized largely by the same groups which would be brought under compulsory insurance, and that insurance contemplates the payment for these services out of the fund, whereas heretofore they were furnished gratis. The state's contribution to the cost of health insurance is, therefore, a more effective way of performing a service, the necessity for which has already been recognized.

WORKMAN'S CONTRIBUTION

Having justified the contribution of the employer and the state, there still remains the question: Should

the workman contribute? The question would seem to be quite preposterous. As we are dealing with an insurance system, the payment of the premium by the insured would seem to require no justification. Nevertheless, it is worth while to point out that the platform of the Socialist party (with a membership of some 100,000 and a voting strength of nearly a million and with many more sympathizers) demands a system of health insurance, as well as all other forms of social insurance, without any contribution from the workman. Similar demands were often made by many radical labor organizations in Europe. As moderate a pair of reformers as the Webbs have severely criticised the British national insurance system because it introduced a complex and cumbersome system of special taxation of the working-men for the purpose of accomplishing something which could be more easily done by general taxation.

After all, precedents in support of this view are not altogether lacking. It is sometimes forgotten that one very important precedent is furnished by the entire practice of compensation, and analogies can easily be found. The whole cost of compensation is by common consent levied upon industry. The charge is accepted because industry is responsible for the majority of industrial accidents; but this is true, though not to the same extent, of a good deal of sickness among wage-workers. Of course, through his own actions entirely outside of the conditions of

his employment, the wage-worker may bring illness upon himself. But even so, no one can deny that a great many industrial accidents may be traced to the carelessness of the employee. The difference is after all one of degree only.

Another important precedent is the system of non-contributory old-age pensions, accepted by a fairly large number of countries (Denmark, Great Britain, France, Australia, New Zealand), which entirely disregards the factor of causation and proceeds from consideration of need only. The same is true of the system of mothers' pensions which has developed recently in this country and to some extent in Europe. At least one country (France) has established a system of non-contributory maternity insurance. It cannot be argued, therefore, that a demand for health insurance without contributions from the insured is altogether chimerical, impractical, revolutionary, and what not.

There are, however, it seems to the writer, besides the certain refusal of the modern employer and modern state to agree to the cost of it, some sound considerations for discarding this plan which, for the present, remove it from the domain of practical politics.

Health insurance deals with temporary disabilities of otherwise economically self-supporting individuals. The cost of illness constitutes a part of the necessary "standards of life" which should influence the amount of wages. It is not at all necessary to place

its entire cost upon general taxation which may again be shifted upon the wage-worker. A non-contributory system of sickness benefits approaching outdoor poor relief, as do old-age and mothers' pensions, must establish a dead level of minimum benefits and does not permit of such extension and adjustment as a system of insurance can. Finally, the contribution of the wage-workers entitles them to a degree of democratic participation in the administration of the funds, such as would be quite impossible under a system of gratuitous pensions. The working class has amply demonstrated its ability and willingness to develop mutual insurance. A system of pensions which would destroy these expressions of mutual aid would be very much less desirable than a financial subsidy of such mutual insurance and its compulsory extension to wider circles. There are sound social reasons, therefore, in favor of contributory insurance entirely irrespective of the objections which employing or taxpaying capital might raise against carrying the entire burden.

Moreover, it is possible to exaggerate the weight of the burden which such a partial contribution to the cost of insurance would represent. It is to be regretted that even as profound a student of labor problems as Mr. Sidney Webb has swerved in this direction. While his earlier opposition to the entire scheme of compulsory insurance¹ has been considerably modified by the study of the results during the

¹ See *Prevention of Destitution*, by S. and B. Webb, chap. i.

first two years, nevertheless even in the Fabian Report² criticism of the "taxation of the poorest" may be found. But is it at all scientific to consider the contribution entirely in the nature of an additional charge, forgetting the returns not only in medical aid, but also in sick benefits, which must in the natural course of events come to every insured? For if the levying of that small charge is a substantial hardship, how much worse must the total absence of the pay envelope necessarily be?

In fact, the assurance of necessary medical care and of a substantial income during illness is a matter of such great importance, that in comparison the question of distribution of the cost becomes a somewhat minor one, so long as there is no extravagant waste involved. Where objections are raised by employees against any contributions because their wages will not permit the charge, by the employers that it is an excessive burden upon industry, by taxpayers against additional burden upon the public treasury, because it must result in higher taxes—it is tacitly assumed that a tax must necessarily remain where originally placed. The tendency to shifting the incidence of taxation is entirely disregarded. Equally crude errors are often made at the other extreme, and many an economic writer has complacently asserted that the entire cost of compensation and other forms of social insurance is finally shifted

² *New Statesman*, Special Supplement, March 4, 1914.

to the price of the product, and thus paid for by the consumer.

The problems of shifting of compulsory charges are undoubtedly complex.³ The working-man will try to shift his charge upon the employer by demanding an increase of wages. The employer may endeavor to shift his contribution either back upon the wage-worker through reduction of wages, or upon the consumer through increase in prices of the product, or both; the state must necessarily raise the amount from somewhere, but which class will be affected thereby depends upon the exact character of the tax, whether it be direct on property and incomes, or indirect, upon some articles of consumption.

So many different possibilities present themselves that a dogmatic answer is difficult. But it is obviously improper to assume as is done by some that the entire burden will fall back upon the wage-worker, partly through his own contribution, partly through increase in prices, partly through taxation. The wage-worker is not the only consumer, he is not (or at least ought not under any sane system of taxation to be) even the main taxpayer, and the strong influence of a customary standard of living upon wages is so well-recognized that at least some shifting of the worker's contribution upon the industry may be expected. It is reasonable to expect that at least partly

³ See the author's "Labor Insurance," *Journal of Political Economy*, June, 1904, pp. 366-67. Also his "Social Insurance," pp. 491-92.

the cost of health insurance will come out of profits and rents. Be it as it may, the shifting of the burden from the shoulders of the sick and disabled upon those of the healthy and earning is the essential thing to be accomplished.

XI

DISTRIBUTION OF COST

THE necessity of dividing the cost of health insurance among the insured workman, his employer, and the state (or society at large) may be set down as "a standard," or a rule of action supported by certain definite considerations. It is somewhat more difficult to be dogmatic concerning the exact ratio of division of the total cost among these three factors. The usual mode of division in European acts has been indicated in the preceding chapter. None of these (neither the German division of two-thirds and one-third, nor the Hungarian division into two equal parts, nor even the British formula of 4*d.*, 3*d.*, and 2*d.*) demonstrates the influence of any logical basis. The ratios are on customary rather than logical lines. An equal division of the cost suggests itself as the natural, because the easiest, way of solving the problem. In the very nature of things the basis for any equitable distribution seems to be lacking. It is only because of the necessity of hitting upon a simple and fair rule that an equal division of the total cost among the employee, employer, and the state is here suggested.

Lacking a logical foundation, this rule may not

deserve to be designated as a standard. The actual distribution will in each case depend more upon bargaining power and the interaction of political influences than upon any definite economic or actuarial reasoning. The representatives of both the employers and employees will naturally strive to reduce the burden to be placed upon their respective constituents. The one rule which may be justified by the more progressive European acts is that the share of employer and employee should be equal, as would be the respective degrees of participation in the management of funds. Perhaps the hardest bargaining may take place in connection with the amount of governmental subsidy. Compromises may here be necessary, and in this connection do not appear very dangerous. So long as the principle of state participation in the cost is carried through, time, helped by the demonstration of the social value of the system, may be relied upon to make this contribution more liberal, if necessary.

It is for this reason that the particular basis of distribution found in the bill of the American Association for Labor Legislation—40 per cent by the employer, 40 per cent by the employee, and 20 per cent by the state—may be approved as meeting the requirements of the particular "standard" established above, at least half way. That the weight of the influence of labor-employing capital will be used against any measure placing an additional charge upon them is perhaps inevitable. But a

substantial contribution from the sources obtained by general taxation may create an opposition from a substantial and influential part of the population which otherwise might not be inclined to antagonize it. It is a part of wisdom not to stimulate such an opposition by asking a large contribution from the state before the public has learned to appreciate the constructive results of health insurance.

REDUCED CONTRIBUTION FOR LOW-PAID LABOR

The demand for entire freedom from participation in the cost, made by the radical wing of the labor movement, finds some justification in the fact that for a certain proportion of the wage-workers even the smallest contribution, in view of the low wage-scale, may present a serious hardship.

This objection is energetically raised by Mr. Webb in his Fabian report, and further emphasized by the use of italics.

"By the insurance premium the state is abstracting from each of their bare cupboards one loaf of bread a week, thereby starving them still further into illness in order to pay for their doctoring and sickness benefit during the illness which the state has thus helped to create."

As the cost of an effective health-insurance system must be substantial, this argument should not be lightly disposed of. Fortunately the British system (many features of which have been so peremptorily

rejected in this study) presents in this connection a very interesting and valuable precedent, in establishing a sliding scale, which provides for a higher contribution from the employer for persons of lower-wage groups.

The actual contributions for the lower-wage groups and the percentages these respective contributions bear to the total are as given in the table on page 172.

The combined share of the employer and the state, which represents the entire subsidy granted by the compulsory system, amounts to 55.5 per cent in case of men earning over 2*s.* 6*d.* per diem (about \$3.65 per week), and to 62.5 per cent in case of all women earning over 2*s.* per diem. It rises with the decrease of wages below these rather low limits until for all workers earning less than 36 cents a day, health insurance is furnished without any cost to them—or, in other words, the “thoroughly chimerical and revolutionary demand” of Socialist platforms is within certain limits realized in staid and practical Great Britain.

If it is true that money wages on the whole are about twice as high in the United States as in England, the same principle of total freedom from contributions should apply to all wage-workers receiving not over \$4.38 per week—perhaps not a large but still not an altogether negligible proportion of female and juvenile workers in the United States.

TABLE I

MALE WORKERS

WAGE GROUP (Per Diem)	Employee's Share Weekly		Employer's Share Weekly		State's Share Weekly	
	Amount	Per cent	Amount	Per cent	Amount	Per cent
1. Over 2s. 6d. (normal).....	4d.	44.5	8d.	33.3	2d.	22.2
2. Over 2s. but not over 2s. 6d.....	8d.	33.3	4d.	44.5	2d.	22.2
3. Over 1s. 6d. but not over 2s.....	1d.	11.1	5d.	55.6	3d.	33.3
4. Not over 1s. 6d..	0	0.0	6d.	66.7	3d.	33.3

FEMALE WORKERS

1. Over 2s. 6d. (normal).....	3d.	37.5	3d.	37.5	2d.	25.0
2. Over 2s. but not over 2s. 6d.....	3d.	37.5	3d.	37.5	2d.	25.0
3. Over 1s. 6d. but not over 2s.....	4d.	12.5	4d.	50.0	3d.	37.5
4. Not over 1s. 6d..	0	0.0	5d.	62.5	3d.	37.5

The principle established by this provision of the British act is an admission of the minimum-wage idea; it amounts to a definite policy to penalize industry for paying subnormal wages. At least this is true of the additional contribution exacted from the employer. Much less logical and of lesser social value is the method of shifting part of the cost upon the state, unless considered as an admission of the general concern society must feel in that part of the working class which is paid these subnormal wages. But even the trace of the old poor-law method of subsidizing low wages, which may be discovered, is objectionable. It would be much more

consistent to charge the employer for the entire difference.

Some such method of relieving the groups of lower earning capacity seems very desirable in American health-insurance laws. An exact schedule for accomplishing this purpose cannot be devised hurriedly, but, simply as a suggestion, the following schedule adopted by the Social Insurance Committee of the American Association for Labor Legislation is offered. Leaving the state contribution, whatever it may be, undisturbed, the distribution of the cost between the employer and employee may be as follows:

TABLE II

	Employee's Share	Employer's Share	State Contri- bution
If weekly earnings are not under \$9.....	40%	40%	20%
" " " " " under \$9 but not under \$8....	53	48	20
" " " " " " \$8 " " " \$7....	24	56	20
" " " " " " \$7 " " " \$6....	16	64	20
" " " " " " \$6 " " " \$5....	8	72	20
" " " " " " \$5.....	0	80	20

Notwithstanding this sliding scale the bill was still criticised for exacting contributions from the low-paid working-girls. How far is such criticism justified? Anticipating the discussion of the cost of health insurance (see chapter xvi) it may be stated that the entire cost will probably vary between 3 and at the very utmost 5 per cent. The actual amount of the weekly contribution of the wage-worker with the above scale in force would be as follows:

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WHEN TOTAL COST OF INSURANCE, IN PROPORTION TO WAGES, IS :

If weekly earnings are :		3 per cent	4 per cent	5 per cent
		Working-men's contribution will be		
Not under \$9	11c and over	14c and over	18c and over	
Under \$9 but not under \$8.....	8 - 11	10 - 14	13 - 18	
" 8 " " " 7.....	5 - 8	7 - 10	8 - 13	
" 7 " " " 6.....	2 - 5	4 - 7	5 - 8	
" 6 " " " 5.....	1 - 2	2 - 4	2 - 5	
" 5.....	0	0	0	

Recognizing all that has been said and written on the subject of minimum wage, and the cost of living for the individual worker, it is still very doubtful whether these contributions, much more likely to come under the first column than under the third, will represent a serious hardship, in view of the returns to be obtained from them. For even dispensary treatment, which is supposed to be free, will cost in nominal charges for consultation and drugs more than these expenditures for weekly dues. For the workers earning less than \$7, these weekly deductions are so small that it is doubtful whether many employers will endeavor to make them. It goes without saying that the raising of the standards so as to abolish all contributions from wages under \$7, instead of under \$5, could meet no serious criticism once the principle is recognized.

It is evident from the entire discussion of the cost of insurance and its distribution among the several elements concerned that there is no one definite economic or social theory underlying it; the theory of benefits to be derived, ability to pay, distribution of responsibility for the existing amount of

illness, are all hopelessly mixed together. This is, however, just what is to be expected from an institution which, notwithstanding many evidences of human ingenuity, represents largely a historical growth. It is worth while to refer briefly to a very interesting and coherent basis for the proper apportionment of the sickness-insurance costs, which has been recently advanced by the well-known actuary and student of social insurance, Mr. Miles M. Dawson, in a private discussion with the writer.¹ Mr. Dawson finds the governing principle of a proper adjustment of the cost of health insurance (or perhaps of all branches of social insurance) in the social responsibility for the amount of illness. Not all of it can be traced to the industry or occupation; but a certain proportion can. It is just, argues Mr. Dawson, that the wage-worker be expected to pay for that part of illness which is normal and independent of occupational influences. That part of it, however, which is due to those influences should be borne by industry. In this way industry will bear not an arbitrary proportion of the cost, too high in some cases and too low in others, but a share proportional to the hazard of disease.

¹ Mr. Dawson's theory is stated here by his special permission.

Since this was written, Mr. Dawson has had the opportunity of making a public statement of this theory at the hearing before the Committee on Judiciary of the New York Senate, held on March 14, 1916, at Albany, New York. See the *Monitor* for April, 1916.

It may be difficult to apportion in each industry the amount of existing illness according to the responsibility, but a broad statistical rule may be established. The occupation with the lowest sickness rate may be accepted as the normal standard. The excess of the actual sickness rate over this normal may, with fair justice, be assigned to occupational causes. If, e.g., according to the data of the Leipzig sickness fund for 1887-1905, the average number of days of sickness per annum for salesmen, clerks, etc., from twenty-five to thirty-four years old is 3.68, and for excavators, construction workers, etc., rises to 12.03, then the difference of the Leipzig sickness fund for 1887-1905, the influences, and for the latter group the employer's contribution should constitute seven-tenths of the cost.

The principle seems to be sound. Since the average rate of sickness for this age group was ascertained to be about 7.79, the employer's share on the average would amount to some 53 per cent, and the wage-workers', 47 per cent. If all ages are roughly thrown together the rate for the office employees is 4.92 days per annum, and for all trades 9.43, and the division again appears to be about equal. An equal division of the cost between the employer and employee appears essentially just on the whole, but not as between one industry and another.

There are of course many practical difficulties in the way. What statistics shall be adopted as con-

clusive? Shall the basis be the average rate of an industry in which there may be a number of different occupations? The administrative problems of ascertaining the proper distribution may be complex. Nevertheless, there is an important element of truth in this suggestion, which will bear careful investigation in the future. It is, however, an entirely new suggestion, not as yet realized anywhere, and at this time it cannot claim its place in the brief list of definite standards.

XII

ORGANIZATION OF INSURANCE

AFTER the substance of health insurance—i.e., the benefits to be granted and the services to be rendered—have been decided upon, the question of method arises. How shall this system of compulsory insurance be organized? The experience with the development of compensation and industrial insurance in the United States has already somewhat familiarized the American people with the various problems of social-insurance organization. In health insurance, however, these problems are of very much greater moment, their discussion must be very much more careful, and an early decision as to the particular form of insurance to be selected is of primary importance for the successful development of the entire plan.

In compensation insurance, the essential problem is that of regulating the duties of one social class to the other. The extent of these duties must be very clearly stated, while in the method of meeting them a certain latitude may be permitted. A compensation law only establishes the employer's liability on a new basis. If the insurance method is made compulsory, it is largely for the purpose of securing

the payment of benefits established by the law. In actual practice, as it has developed in Europe as well as in the United States, a great variety of insurance-carriers conduct compensation insurance, beginning with private-stock insurance companies, and up to purely governmental insurance funds.

Thus one finds that state insurance is the exclusive form in Washington, West Virginia, Oregon, and Wyoming, and also (with a few exceptions) in Ohio. State insurance funds exist side by side with private commercial insurance-carriers in California, Colorado, Michigan, Maryland, New York, Pennsylvania, while in most of these states and many others mutual insurance of employers is not only permitted but even encouraged, and at least in two states government authority has organized mutuals, leaving them in the hands of the membership. Moreover, in the face of many forms of insurance-carriers, only in a very few states is insurance quite compulsory; in West Virginia, Massachusetts, Texas, compensation is elective but, once accepted, insurance compulsion follows; in many states, while insurance is ostensibly compulsory, yet self-insurance is recognized as one of the many forms of insurance, and self-insurance simply means relief from insurance compulsion upon sufficient evidence of solvency; finally, in a few states no requirement at all as to insurance is found in the law.

In other words, the insurance features are recognized as of secondary importance, and the heated dis-

cussions of these features are largely due to the struggle of commercial insurance to remain in this branch, which as yet has proven to be fairly profitable.

Competition is frequently allowed between insurance-carriers of different types because it is believed that such competition will reduce the cost of insurance. It is usually assumed that the employers' class, being the class possessing business sense, will be able to decide as to the comparative advantages of the different insurance-carriers. Of course, public control over the private insurance-carriers is often found necessary, in order to secure fair adjustments of claims. Where state insurance-carriers conduct the business, they are usually self-supporting. If a state subsidy is given, protests are frequently heard that this is an unjustifiable dissipation of public funds for the purpose of subsidizing private employers, who are not the objects of social insurance.

The situation is evidently different in case of health insurance, where a considerable share of the cost is borne by the very class whose economic interests are to be protected. Contributions from the employer, and, in some countries, from the public treasury as well, are justified largely by the inability of the wage-workers to meet the entire cost.

The object of social health insurance is to give the insured as large a return for their contributions as possible. As a result, practically all social insurance against sickness in Europe is conducted by institutions or organizations of a public character,

with the element of commercial profit entirely eliminated.

As to the actual type of the institution, there is considerable variation. In American literature the term "social insurance" is often used interchangeably with "state insurance." Yet there is very little direct "state insurance" in the field of health insurance, such as is found in the German old-age insurance system, or in the various state insurance organizations provided for compensation insurance in several American states. The term "state insurance" may be applied only in the sense of a very definite control, supervision, regulation, and financial subsidy. But in face of all these facts, a public co-operative institution may be very distinct from a state institution.

Perhaps the British system of all European systems of sickness insurance comes near to being a state insurance system, but even then, as will be explained presently, the insured individual deals with a public organization of a local character, and only the latter carries on certain financial transactions with the state.

It is important to keep in mind this distinction between "state" and "public" insurance-carriers, because already there may be observed symptoms of a tendency in this country to carry the principle of direct state insurance from compensation into the sickness field. At least a few bills have been drawn to that effect. It is too early to say whether

even in compensation the principle of bureaucratic state insurance has proved a success. But the entire growth of health insurance has been through development of co-operative effort and democratic organization, and their results are too great to be neglected in favor of purely bureaucratic management.

As already indicated, the type of health-insurance organizations must largely depend upon the generic plan of insurance, whether it is voluntary or compulsory, and if the latter, whether the compulsion to insure leaves the choice of the particular carrier free to the individual. In the three countries taken as types, all the three forms may be recognized.

In Denmark, the whole organization being voluntary, insurance is carried on by voluntary "recognized" societies. The state grants "recognition" and subsidies, in return for which it retains the right of supervision, and prescribes certain conditions which tend to standardize the activity of the fund. The one definite requirement which it must strictly enforce is that the organization receiving recognition and subsidy be kept free from any private profit-making.

Impartially the state is ready to encourage all types of organization, and if nearly 95 per cent of these funds are of the local type, embracing members of different trades and occupations, in a definite locality, that is the result of spontaneous growth. The remaining funds are either "trade funds" or

factory or establishment funds, also local in their character.

Undoubtedly establishment funds have a certain administrative advantage, provided they are big enough for insurance purposes. Trade funds have the actuarial advantage of a tendency toward greater uniformity of sick rate, but they are practical in large cities only.

The variety of health-insurance funds existing in Germany has often been noted in American writings. It is unnecessary to go over the details of the different funds—local sick funds, establishment funds, building, miners', and other trade funds, mutual aid funds, and the recently organized rural sick funds.

Nevertheless, the German system is built upon the principle of *Zwangsversicherung*—i.e., insurance with prescribed carriers. The seeming inconsistency between the principle of *Zwangsversicherung* and the variety of existing types is not sufficiently understood by American students and requires some explanation.

All compulsory health insurance has grown out of voluntary mutual insurance. The situation found in Denmark at present existed in Germany at the time the sickness-insurance law was adopted, though perhaps not in the same degree. The existing spontaneous institutions (local, trade, and establishment funds) were too valuable to be destroyed; besides, to destroy them would have created a serious

opposition to the whole plan. The existing institutions were preserved, and even the future formation of such forms of sick funds, which often have their distinct advantages, was provided for. Nevertheless, the ideal or normal types were indicated in the law. These are the local funds, either for all trades, or for special trades, and establishment funds.

Notwithstanding the multiplicity of funds, the choice is not left to the individual (except for the mutual-aid funds, referred to presently). The organization of exceptional funds was made subject to collective decision and governmental approval. Nevertheless, the history of thirty years of insurance has indicated the preference for local funds over all others, even over the establishment funds. Within the local funds themselves, a process of consolidation is taking place.

The inclusion by the act of 1911 of the two large groups, domestics and farmhands, led to the establishment of a new type, the so-called rural fund, which is also a local fund for workers of a lower wage scale. Out of some 20,000,000 insured, about 7,500,000 are insured in local funds, another 7,500,000 in "rural" funds, and 3,000,000 in establishment funds, leaving only 2,000,000 for all other forms of funds.

Among the local funds, the Leipzig fund, which embraces the whole city, is justly famous. Membership in mutual-aid funds (comparable to friendly societies or fraternal orders) as a substitute for in-

urance in the compulsory institutions is only tolerated, and at the price of forfeiting the employer's contribution.

It is not difficult to ascertain the reasons for this tendency. Health insurance is primarily a matter for local administration. A great deal must be lost by the geographic extension of the organization. For one thing, the control over the beneficiaries is simplified by localization.¹ The financing is made very much cheaper, for the amounts dealt with, both in the income and in the outgo, are small. And perhaps the most important factor is the facility of organizing proper medical help, which is a very difficult undertaking for an organization with a scattered membership. Even the establishment funds, though possessing the advantages enumerated above, are not so desirable as the ordinary local funds, because of the predominating importance of one employer and the financial danger which may develop out of one localized epidemic.

Although the British National Insurance act has made very extensive use of German precedents, yet the organization of the health-insurance system in Great Britain has been built on diametrically oppo-

¹ See "Appendix to the Report of the Departmental Committee on Sickness Benefit Claims under the National Insurance Act," especially Vol. I of the "Minutes of Evidence," for evidence of the serious administrative difficulties, especially in respect to medical aid and duplication of expense, because of centralization of the work in home offices of large "approved" societies in Great Britain.

site lines. Its basis is unrestricted freedom of choice as to the insurance-carrier. It is quite well understood that this is in deference to the strong British friendly societies, which correspond to the German mutual-aid funds (*Hilfskassen*) but have reached a very much greater degree of development. Not only did the British law leave these organizations undisturbed, it even refused to prescribe a definite form of organization to supplement them. It is perhaps idle to speculate whether the authors of the British act were wise in this decision. The compromise was forced upon the British government by the strength of the friendly societies, for it is quite certain that no bill could have passed in face of a united opposition of the five or six millions of members of friendly societies.

The British system is therefore based upon a voluntary choice of membership in some recognized mutual organization. At the same time the organizations have a practically unrestricted right of rejection of members (because the prohibition of rejection on the ground of age cannot be of practical value).

What were the practical results of this system?

1. While it is true that the membership of the friendly societies has increased considerably, the most noteworthy feature was the establishment of "recognized" societies by private industrial life-insurance companies, the membership of which exceeds five millions. While these "societies" are sub-

ject to the requirements of the law as to prohibition of profits and as to democratic management, it is nevertheless very doubtful whether this strengthening of the industrial companies was contemplated by the National Insurance act.

As a matter of fact experience has demonstrated that very little if any democracy was left in the organization of the six approved societies of the Prudential Insurance Company. "It is ludicrous," says Mr. Webb,² "to talk of democratic self-government in the gigantic new societies with hundreds of thousands of members scattered all over the Kingdom, but controlled by a strictly centralized administration the nature of which probably none of them understand." And while it is generally admitted that the administration of these societies has on the whole been satisfactory to their members, yet the practical denial of the democratic spirit must be a distinct loss, because it fails to arouse the membership to a sense of responsibility, and to stimulate the work for disease prevention among them. In fact it is even questioned whether the organization of these "Prudential" societies fulfils the object of the law which requires democratic administration.

2. The lack of strict geographic limits of the activity of the friendly societies has created a very complex administrative problem of the "isolated member." In every large English city thousands of organizations have their representatives. The de-

² *New Statesman*, Special Supplement, March 14, 1914.

gree of participation of these members in the affairs of the societies must necessarily be purely nominal, the control of the society over the beneficiaries difficult, malingering must necessarily be stimulated. The relation which must eventually prevail is rather that of an insured to the insurance-carrier than of a member of a co-operative institution to his fellow-members.

3. A direct relationship between the friendly society and the medical organization became quite impossible, especially because of the lack of correspondence between geographic limits and society limits. A very complex organization of medical aid became necessary whose working efficiency compared with that in Germany must be low. The very task of bringing the physician and the insured together became a matter of great difficulty, requiring a complex system of various card catalogues with many millions of cards.

4. Finally, the system created the problem of the uninsured, either because of unwillingness or because of inability to obtain membership in a "recognized" society. The solution of this problem by establishing the so-called "post-office contributors" is not a very happy one, since these are insured only up to the amount of their individual contributions, or rather not insured at all, but required to start compulsory saving accounts of very little value. It is true that the number of these residual "contributors" is not very large—only about half a million.

Nevertheless they present an additional argument against the unsatisfactory methods of organization of the British health-insurance system.

The experience of other countries corroborates that of Germany. In Austria practically the same situation exists, with a variety of insurance-carriers of different types, but the local society predominating and the selection of the carrier being largely a collective, and not an individual matter. In Russia the prescribed type is the establishment fund (the sick benefit society of one industrial establishment) or the combined fund of several smaller establishments; but this is largely explained by the fact that the Russian act of 1912 is primarily limited to factory employees. In Norway, Servia, Roumania, and the latest addition to health insurance, Holland, new, largely local, funds have been created, although in most counties workmen are permitted to retain their insurance in other existing organizations.

What is the lesson of European experience in regard to the most practical and efficient method of social insurance against sickness which should be advocated in this country?

The first lesson is obvious—that private insurance enterprises operating for profit have absolutely no place in the scheme. The English exception is only a seeming one, because, while the Prudential and other industrial insurance companies have succeeded in organization of over 5,000,000 persons

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into their societies, yet they do not constitute a part of the insurance enterprise and no profit can be received from them, except indirectly. It is generally understood that the object of the British Prudential Insurance Company in organizing these approved societies was primarily to protect its life-insurance business.

The claims of the private commercial insurance companies writing accident and health in this country are more far-reaching. While the smaller companies, which write almost exclusively this so-called "industrial health business," have energetically protested against social health insurance as likely to injure their business interests,^{*} suggestions are already being made that private stock insurance companies, operating for profit, may be utilized in this branch of social insurance as they have been in compensation.

There can be very little doubt that when the legislative progress of compulsory health insurance is sufficiently advanced, energetic efforts will be made to swing legislation in that direction. It is wise, therefore, to face this question squarely at the outset. In arriving at a decision, the following circumstances must be taken into consideration:

^{*} See "The Health and Accident Underwriters' Conference held at Cincinnati, Ohio, February 25, 1916," as reported in the insurance papers for that period, particularly the paper by Mr. T. Leigh Thompson, "The Un-American Doctrine of State Compulsory Health Insurance," *Economic World*, March 4, 1916.

1. European experience is unanimously opposed to such a plan. There is not a single precedent in favor of such a course, though private compensation insurance is admitted in many countries, such as Great Britain, Italy, France, Belgium, Spain, Sweden, and others.

2. While the compulsory system calls for no expensive agency system for solicitation of business, such a system will persist under the management of stock companies, for the purpose of inter-company competition. Thus another substantial channel of economic waste will be preserved.⁴

3. The introduction of private insurance business and the underlying element of profit will make the administrative problems of claim adjustment very much more difficult. At best, one must not close one's eyes to the possibility of disagreements and misunderstandings between insurance carrier and claimant, especially in the early stages. These conditions must be aggravated by the existence of the motive of private gain.

4. The past experience with private accident and

⁴ "A number of companies are offering the policy fee (i.e., the initial payment made by the insured at the time of issue of policy), the first month's premium, 35 per cent of renewal premiums, and allowances for rent and expenses. . . . In 1914 the total agency or acquisition cost of business was 32.23 per cent, in 1915 32.85 per cent, an increase of .62 of 1 per cent." Address of Mr. Louis H. Fibel at the regular meeting of the Health and Accident Underwriters' Conference at Cincinnati, Feb. 25, 1916.

health insurance among working-men in the United States offers very little support in favor of such contention. In a very comprehensive investigation of 14 companies, writing this form of insurance, undertaken in 1911 by a committee of the National Convention of Insurance Commissioners,⁴ the conditions discovered were characterized by the committee as "deplorable."⁵

In the guarded language of the report "the Committee feels warranted in concluding that when dealing with companies doing an industrial health or accident business, the policy-holder public of the country—particularly those who through ignorance or poverty are unable to protect themselves, and therefore are particularly the wards of the government—has too frequently been the victim of unconscionable practices in the claim departments of the companies."⁶ Pages could be filled with the disgusting details of the deceptions practised, but it is sufficient to state that in the case of the largest and perhaps the worst of these concerns the insurance authorities demanded and obtained the resignation of the manager of the claim department, his wife, brother, and brother-in-law, all of whom were employed

⁴ See *Investigation of Settlements with Policyholders by Companies Doing an Industrial Health and Accident Business*, being Vol. II of *Proceedings of the National Convention of Insurance Commissioners of the United States*, held at Milwaukee, Wis., Aug. 22-25, 1911.

⁵ *Ibid.*, p. 87.

⁶ *Ibid.*, p. 88.

in the same company and were directly concerned in the reprehensible practices. And perhaps nothing better illustrates the morale of the business than the fact that the gentleman in question had no difficulty in obtaining an important position with another concern and remained a leader in the business.

5. Even though such conditions are not universal, and some improvement may have taken place within the last five years, the fact remains that the loss ratio—i.e., the proportion between the amount paid out for claims and the premiums collected—varied from 30.6 to 46 per cent, that is, the expenses of conducting the business and the profits absorbed from 54 per cent to 70 per cent of the premiums. Only in the case of 2 companies did the loss ratio rise above 41 per cent, and in the case of 8 companies it was less than 37.5 per cent.*

6. The organization of medical aid for the purpose of making health insurance a measure of prevention and cure as well as of relief would be made very much more difficult under private insurance management. The safety work of private insurance companies has been emphasized perhaps unduly,

* "Claims and claim expense [i.e., expenses in connection with adjustment of claims] absorbed in 1914 45.18 per cent of the premiums and in 1915 44.79 per cent, a reduction of .39 of 1 per cent. . . . It would seem that we are now returning to our patrons a very fair percentage of the premiums they pay us [sic!]. It would be a splendid thing for all concerned if this ratio could be larger, but present conditions do not seem to warrant it."—Louis H. Fibel, *loc. cit.*

because obviously the reduction of hazard may result in commercial advantage. But while such harmony between sound business considerations and social welfare may occur, it is evidently undesirable to make the important work of health conservation depend upon the possibility of commercial gain. In so far as reduction in morbidity may result in savings, these savings should accrue to the working class, and not to outside profit-seeking interests.

7. Private organization of insurance would altogether destroy an advantage of direct participation of all parties concerned (both employer and employee) in the health-conservation campaign.

8. Little can be expected of voluntary extension of the insurance benefits beyond the required minimum. Many other considerations might be mentioned. Enough has been said, however, to indicate that the permission to stock insurance companies to extend their activities into the field of social health insurance would result in very serious harm to the entire movement. This is so well recognized in Europe that the suggestion was not even seriously made.

The case is perhaps not so strong against the participation of mutual private insurance companies. For one thing, one element of profit, dividends to stockholders, has been eliminated through the recent mutualizations of the large industrial life-insurance companies. The wide and often highly useful activity of some of these companies in the field of preven-

tion, dissemination of useful knowledge, collection of valuable statistics, is mentioned as an argument in their favor. And yet, at least some of the arguments above enumerated retain their force. The democracy of mutual insurance companies with millions of policy-holders, scattered over the land, after all exists purely on paper. And while the present management is admittedly both efficient and honest, there seems to be little reason for turning over into their hand an institution of tremendous social value, which should develop into a powerful school of efficient self-government for the millions of wage-workers.

It seems equally certain that the lesson of European experience is not in favor of the method of direct insurance by the state. In a certain sense the British system may be described as such a direct system. Though ostensibly based upon a freedom of choice as to the insurance-carrier, and shaped with due and perhaps excessive regard to the wishes of friendly societies, it nevertheless concentrates the financial transactions in a governmental commission, where a bewilderingly complex system of bookkeeping controls the income and outgo of every "approved" society, the transfers of membership, and the resulting movements of reserve values, etc. The system is "national" in that it embraces the whole nation, but is largely governmental in its operation, and much less "national" in the better sense than is the German system.

Outside of this one precedent the entire lesson of

history is in favor of the "local" public fund, whether built upon trade lines, where the number of insured is sufficiently large, or embracing all the wage-workers of a locality. Of course no purely mechanical regularity as to these local funds need be required. As a rule it is desirable that they agree with the political subdivision, whether it be a county, township, or school district. In larger cities the organization of numerous funds may be encouraged in the beginning, because the administrative problems of such large funds as that of Leipzig are complex and should not be handled lightly.

While the "local" fund should be put forth as the new organization to be created by the law, and also the typical one, it must not be made exclusive. The existing conditions and organizations must be carefully reckoned with. In approaching the problem of health insurance the United States finds itself in about the situation in which Germany was thirty years ago. All kinds of voluntary sickness-insurance carriers exist, though the actual extent of their operations is unknown. A governmental investigation some seven or eight years ago indicated a membership of a little over one million, but failed to canvass the entire field, especially as to establishment funds and local sick-benefit societies.* Since then the development of establishment and other funds has

* See "Health Insurance, Its Relation to the Public Health," by B. S. Warren and E. Sydenstriker (U. S.), *Public Health Bulletin* No. 76, p. 80.

been very rapid. Perhaps fortunately, the American fraternal orders corresponding to the English friendly societies have selected the field of life insurance rather than that of health insurance, and therefore the influence of the existing organizations will not be so great as it was in Great Britain.

Yet already at the recent hearing in Albany representatives of fraternal orders protested against the health-insurance bill on the plea that it may interfere with the development of their organizations. It is understood that several fraternal orders have recently made efforts to develop sick benefits within their organization, but no one can tell with any degree of certainty how far their development has proceeded. The representative of the fraternalists spoke of the "thousands" already insured against sickness, and the natural rejoinder followed that compulsory health insurance had in mind millions and not thousands.¹⁰

Be it as it may, no unnecessary opposition need be created, and some place must be provided for the existing efficient organization.

The following forms of health insurance, already existing or to be created, may therefore be easily incorporated in the general scheme.

¹⁰ See report of the testimony in the *Monitor*, official publication of Associated Manufacturers and Merchants, Vol. II, No. 10. Buffalo, March, 1916.

TRADE FUNDS

In large centers these undoubtedly have a certain advantage of community of interests between workers in the same trades. Besides, the existing trade-union health-insurance funds may be readily adjusted so as to fall in with the general scheme as here outlined. In the larger cities, the presence of a cosmopolitan and polyglot population may make large local funds somewhat difficult, and in view of the well-known tendency of many nationalities to concentrate in special trades, trade funds may have the additional advantage of racial homogeneity.

Moreover, a trade fund may often present the advantage of greater actuarial equity, because the rates of contribution may be more easily adjusted to the peculiar rate of sickness (whether exceptionally high or low) within the specific trade.

ESTABLISHMENT FUNDS

These are gradually gaining popularity. Under present conditions of lack of control they are subject to many abuses, among which perhaps the most important are the insecurity of funds handled by the employer, and the arbitrary administration by the latter. But with these conditions eliminated there is no reason why, in large establishments, funds should not offer a very convenient carrier for health insurance, provided their activity is adjusted at least to

the minimum requirements of the law, and their democratic administration by the insured together with the employer is guaranteed. Of course, under certain conditions an establishment fund may present a danger—especially in smaller industrial communities, when one establishment plays such a predominant rôle in the local industrial life that outside of it insufficient material would be left for proper health-insurance organization. Under such circumstances the local fund would practically be an establishment fund and a separation of forces would scarcely be desirable. The permission to organize special establishment funds should, therefore, be granted only subject to due consideration to the local situation.

BENEFIT SOCIETIES

Perhaps the most difficult problem is that presented by the existing sick-benefit societies, largely operated by working-men, but not on trade or local lines. The German *Kranken- und Sterbekasse* and the Jewish *Arbeiterring* are examples of these organizations. Often the social and political purposes of such organizations are as important to their membership as the functions of insurance. Their membership is scattered; it is not always limited to persons who would be subject to compulsory insurance. What shall be done with them?

As participation in the insurance scheme car-

ries with it substantial financial subsidies, pressure to admit these organizations may be expected. But, as will be explained later, the employer's subsidy must carry with it his right to participate in the administration of the health-insurance fund, and these voluntary organizations are not likely to meet with favor any suggestions as to relinquishing to the employer their present independence. This alone would furnish many reasons for friction.

If these independent organizations are permitted to enter the field of compulsory health insurance, on terms of complete equality with the compulsory local associations, a direct stimulus will be given to them for active soliciting of new membership, and a selection of risks will result to the detriment of the regular local funds. In other words, a wedge would be opened for the British system with all its drawbacks.

It seems preferable to make an effort to eliminate them before they become a stronger factor in health insurance than they are now. Of course, that does not mean that their existence must be interfered with. But if membership in one of these organizations seems to any worker preferable to that in the usual local funds, that may be permitted at the cost of forfeiting the subsidy coming from the employer, for, in addition to the general considerations advanced above, the employers will strenuously object to contributing money to working-men's organizations, without obtaining any right of participating in the management of the fund. There seems to be

no serious objection to granting them the state subsidy, as evidence of good faith on the part of the state, and the absence of any desire on the part of the state to destroy them, if they can prove sufficient efficiency of management.

German experience shows that, notwithstanding certain limitations imposed upon these sick benefit societies, a certain membership in them will persist. Moreover, these strict conditions need not at all preclude the activity or even further development of the voluntary societies. Most of them combine other forms of insurance with that against sickness. They may still go on with those other forms, especially that of life insurance; and the fact that substantial health insurance will be obtained by their members through the regular compulsory system, at a lower cost to themselves, will permit a greater development of life insurance than before. They may also furnish additional insurance against sickness (the benefits under the compulsory system being necessarily limited).

It must be remembered, however, that the persistence of those voluntary sick-aid societies creates a certain danger of over-insurance, a danger which to a certain extent exists even to-day. "Over-insurance" technically designates a condition under which the possible benefit at the incidence of loss is greater than the loss insured. Commercial insurance wisely endeavors to prevent over-insurance. The layman often experiences difficulty in under-

standing the reason for this. Since larger insurance carries larger premium, he sees no reason for controlling the amount of insurance. But the fire-insurance man knows that over-insurance either demonstrates criminal intent, or often tempts to arson, or at least gross carelessness. The life-insurance underwriter looks suspiciously at an insurance for an amount out of harmony with the applicant's state in society, either suspecting that suicide is contemplated or fearing that the over-insurance itself, in face of financial difficulties, may suggest suicide as "a way out."

The temptation to fraud because of over-insurance is still greater in case of health insurance, because fraud may be perpetrated without criminal action such as arson, and at a much less sacrifice than suicide, in fact without any sacrifice at all, by sheer effort at malingering. The situation is extremely unhealthy when the person is assured a larger income when disabled than if he returned to work. Nevertheless, invariably our mutual sick-benefit societies refuse to take over-insurance into consideration and permit the duplication (or even more) of the benefits. The introduction of compensation, e.g., did not move these societies to establish rules excepting compensated accidents from the benefits, as they should. The insured workmen also object to being thus "deprived of benefits for which they paid," forgetting that thus they might have reduced the cost of insurance to themselves. But unless health

insurance is directly intended to stimulate valetudinarianism if not malingering, increase of benefits through membership in voluntary societies beyond the full income at most, (and preferably 90 per cent), should be strictly prohibited.

XIII

ADMINISTRATIVE ORGANIZATION

IN the preceding chapter the essential features of the necessary insurance organization were outlined. The actual method of administration of these insurance-carriers (the choice being for local associations) represents an independent problem.

The voluntary sick-benefit societies have their own administrative systems, often greatly differing from one another. The same is true of the establishment funds, some of which are altogether in the hands of the employers. The existing trade sick-benefit systems are administered as a part of the trade union. The local associations are to be created anew. What system of administration should be provided for these new organizations, and how far shall that of the existing bodies be modified? Shall certain uniformity be established? Shall rigid governmental control prevail? Or shall the entire administration be placed in the hands of government officers, elected or appointed? It is evident that many possibilities arise. What shall be the guiding principle of selection?

One obvious principle is that of efficiency. Combined with it is that of economy. But perhaps equally important is the principle of democracy of administration.

The necessity for efficiency and economy scarcely requires any proof. But why democracy? Unless out of general social considerations? There are, however, several very pragmatic considerations why the principle of democracy cannot be disregarded in the administration of such an important social institution as health insurance.

1. Democracy is necessary for the purpose of developing the services of insurance to the widest extent. Without democratic management, little beyond the prescribed minimum of services can be expected, as the opposition to additional taxation would be very great.

2. Democracy is necessary for the purpose of preventing the development of a tendency to malinger. The reason why insurance often proves a fruitful source of fraud is that even men of average honesty fail to recognize the element of crime in imposing upon an impersonal insurance institution. Democratic management has the tendency of placing every member on his honor.

3. Democracy must stimulate the work of prevention. Not only does the feeling of concern for the organization produce a salutary effect upon the individual, but the effect is further transmitted from one individual to the other. A democratic institution has a splendid opportunity of becoming a powerful educational influence in the campaign for health preservation.

4. And last, but not least, democratic manage-

ment is almost a *conditio sine qua non* of the introduction of the system for the working classes who have already been accustomed to democratic insurance organizations and would offer a very obstinate opposition to a purely bureaucratic organization.

Of course, it has been claimed, and frequently with justice, that democratic management is often found incompatible with the highest degree of efficiency. Not only in commercial and industrial, but even in political life, a tendency may be observed to glorify autocratic administration as most efficient. It has been said with a great deal of truth that in the proper harmonizing of efficiency with democracy lies the great secret of good government. The general solution of this difficult problem need not be undertaken at this place. It may be readily admitted that, whatever the theory, in practice democracy usually results in a certain loss of momentum and efficiency.

That may well be true as far as certain aspects of business administration are concerned. But as against it, the democratic management of a co-operative institution catering to large numbers has a tremendous advantage of loyalty which must result in very great economy and even efficiency.

Specifically, democratic administration of a mutual insurance-carrier presents the following advantages:

Cheaper administration because a democratic

form attracts the leaders of the working class who are anxious to work for the workman's organization out of consideration of party loyalty;

A very large amount of free service in the care and control of the sick, through a system of committees;

A sense of responsibility on the part of the claimants, which minimizes the danger of malingering.

These advantages are found in the present mutual-aid societies and other working-men's organizations and they explain the popularity and loyalty which they create though often suffering from inefficient financial management.

And last, but not least, must be mentioned the social aspects of democratic management, which have an intrinsic value of their own.

The aim should be to preserve these advantages of democratic management as far as possible. Some features must, however, be abandoned.

To begin with, it is extremely doubtful whether it is possible (or even desirable) to leave these associations in the hands of the working-men and women alone. The employers, according to the scheme here outlined,¹ contribute an amount equal to that of the employees. Moreover, the exact amount of contribution is left undecided and depends upon the efficiency of management. The employers, therefore, have a vital interest in the finances of the associa-

¹ See p. 169.

tion. It is, therefore, idle to expect them to forego a voice in the management.

Nor would it be desirable. It cannot be denied that the employers have a wider experience in matters of financial administration. Again the reduction of the sick rate depends upon the sanitation in the factory and shop, which may be carefully prescribed by laws and regulations, but can never escape the influence of the employer's direct concern in the health of his employees. The employers' participation in the affairs of the health-insurance association should on the whole be a salutary one.

Since the contributions of the employers and employees are equal, it seems the fairest way to give the two sides equal representation in the administration. It is true that we are confronted with the German precedent, which gives the wage-worker two-thirds of the voting power, and that power is frequently resisted by the employer and jealously guarded by the employees. But it must also be remembered that the German working-man contributes two-thirds of the cost, so that voting strength in the administration is proportionate to the contribution, which is the plan outlined here. It is reported that the radical elements of the German working class rather feared a reduction of the working-man's contribution, because it would have carried with it reduction in the working-man's influence over the affairs of the insurance association. But the price of this preponderance in the voting power seems to be a

somewhat excessive one. If the activity of these associations is strictly limited to the functions prescribed by the law, some disagreements may be expected, but there appears no necessity for excessive friction. Of course, strict accountability to state authorities, and a right of appeal against unjust acts should be carefully guaranteed.

On the whole it seems more desirable that no official representatives of the state authority be directly concerned in the administration of these associations, since this would present the danger of saddling the system with a large number of unnecessary employees, or on the other hand, might result in the state officer, as the carrier of the balance of power, centralizing under himself the entire management of affairs.

There seems to be no necessity of making the details of organization and administration absolutely uniform for all associations, in view of the many racial and local differences. Only the general outlines may be embodied in the law and need to be discussed here. Each association must necessarily have its own constitution and by-laws. A requirement that these constitutions and bylaws should be subject to approval of the central administrative authority would appear to be a sufficient guarantee of uniformity in the essential features. The equilibrium between the employers and employees must be achieved in a small body acting, whatever its official designation, as the highest administrative

authority of the association. Since, however, there must be a substantial difference between the number of employers and employees, either group must conduct its election independently. This administrative body (executive committee or board) may act either through its own officers, or, in larger associations, through hired administrative officials. In addition, however, since the associations planned are of substantial size, and general meetings may be difficult or useless, a representative body of large size, controlling the actions of the administrative committee, may be desirable. In all these representative bodies the two sides may vote separately, and a majority vote of either side may be required if the problem concerns the general policies of the association, such as the voluntary increase of benefits.

CENTRAL ORGANIZATION

What has been said above refers primarily to the organization of the local insurance-carrier. This, however, must be an organic part of the entire system.

Constitutional difficulties will probably make any national system of health, or any other form of social insurance, impossible for many years. If progress is to be made in the near future, it must be, as it was in the case of compensation, on state lines. The brief experience with compensation has already indicated the main conditions of success of

such social legislation. If special administrative commissions with wide judicial and even semi-legislative powers delegated to them were found necessary for the successful administration of compensation, similar commissions will be needed for health insurance. Nor does there seem indicated a combination of both branches of insurance in one commission, except perhaps in the smaller states. Quantitatively the problem of health insurance is the larger of the two. The proper launching of the system, the relations of individual members to the funds, the problems between the employer and employee, between employer and fund, between funds and the medical profession, between the funds and the state, the proper regulation of membership rates, the organization and the regulation of medical service, etc.—these are some of the problems that must be handled judiciously and expeditiously, as can only be done successfully by an efficient commission.

There have, however, recently developed two definite tendencies in American state government which are urged against this suggestion of a special health-insurance commission. One is a "reaction against special commissions," and another a somewhat exaggerated enthusiasm for industrial commissions for administration of all labor legislation. Because of these two tendencies it is urged that the administration of the health-insurance system be placed within the industrial commission where one exists, or within the labor department.

No very serious question of principle is involved in either of these suggestions, and perhaps it is scarcely worth while entering here into detailed discussion of the general tendencies of administrative practices in the United States.

Proper administration of laws, especially constructive laws, requires efficient administrative organization. The complexities of a compulsory health-insurance system are such that surely autocratic administration through one all powerful official is not desirable. The problems which will require decision will largely be problems of conflict of interest which should not be left for final decision to one individual, overburdened at the same time with executive details.

If the principle of a special board or commission is recognized the question whether it is organized altogether independently or within a larger industrial commission is of minor importance. But it is of importance to recognize that a complex health-insurance organization, with its health preservation work as a side issue, cannot be sufficiently managed by men who at the same time are expected to render decisions on accident compensation, industrial safety, arbitration of strikes, and other matters.

"Industrial commissions" as such have recently become popular among students of administration. But neither names nor forms of organization offer a sufficient guarantee of efficient administration, which must depend upon honesty and efficiency of men.

Of the existing industrial commissions some have undoubtedly proved very effective. But no one could claim that uniformly the selection of the men was proper, nor that they all have been equally successful. Especially strong is the evidence becoming that most of them successfully develop one or a few of their functions and woefully neglect others. If efficient administration means administration by experts, specialized commissions offer a better guarantee that such experts will at least gradually develop.

XIV

FINANCIAL ORGANIZATION

AMOUNT OF CONTRIBUTIONS

IN an earlier chapter certain definite rules were laid down as to the distribution of the entire cost, among the three main parties concerned, and these rules were based upon general social considerations. The important technical problem remains, as to how the total amount shall be computed and what it shall be. Shall we endeavor to build up one uniform scale of contributions, such as only the British system, of all systems, possesses? The amount of contributions evidently depends upon the benefits and services which must be given. Since we have discarded the British system of uniform benefits (for reasons already discussed at sufficient length), it necessarily follows that uniform contributions for a varied scale of benefits would not be at all an equitable arrangement. The contributions evidently should bear some relation to wages, since benefits do. Yet all vexed problems are not yet solved by this decision. Shall the contributions then be stated in terms of a percentage of wages, the same percentage for all wage groups? Since only the money benefits are adjusted to

wages, but the entire medical service is not, actuarial justice would require a percentage of wages which is increasingly higher as the wages become lower.

It is well known that the rate of sickness increases with age. Shall rates be adjusted to this difference and rise from year to year, as would the cost of term life insurance, if taken out for a 1-year term only? Or shall it increase from one age group to another, by 5- or 10-year groups, as does the cost of term life insurance in actual practice? Or shall a level-premium system be adopted, familiar to Americans from life-insurance experience, where a uniform premium is guaranteed for the entire period of insurance, but varies with the age at which insurance is effected? This is the British system, though it does not appear quite readily on the surface, because, instead of the contributions increasing, the benefits are reduced for all persons entering insurance at an advanced age (except during a certain period of grace).

A still more important factor than age in causation of sickness is the industry or occupation. It seems unnecessary here to prove this contention. Shall this factor be disregarded, as was done in the British act, or taken cognizance of in establishing rates of contribution? Shall local differences be taken into consideration? It is well known that the general rate of sickness may be substantially influenced by climatic and general hygienic conditions. How far shall these differences be taken into con-

sideration in computing rates? And embracing all these particular problems, there is one general problem—Shall the law contain any specific provisions as to the actual rates to be charged for the insurance furnished?

This question must necessarily arise because of the weight of the British precedent. A study of the history of the British insurance system, especially of its preparatory stages, emphasizes the prominent part taken by actuaries and their computations. The wealth of actuarial tables accompanying the "Reports on the Administration of the National Insurance Act," with their complex mathematical formulae, depresses and discourages the non-mathematical student. Not only do the general provisions of the act, such as the relation between the contributions exacted and the benefits promised, depend upon these computations, but a great many minor features as well, such as those determining the reserve values which must be credited to societies for the admission of each member over sixteen years, those for calculating the rights of insured women at marriage, and so forth.

It would be unwise to tax the reader with actuarial computations at this place. But for the purpose of an intelligent decision as to necessary legislation about the rate of contributions, the essential actuarial problems underlying the organization of health insurance must be stated.

The entire science of life-insurance rates is based

essentially upon two factors—an assumed table of mortality and the laws of compound interest. The conditions of the insurance contract are simple. The payment of the premium depends upon survivorship, the payment of the death benefit upon death. There are no different kinds of losses. There is of course a considerable difference between the rates of mortality of different occupations, and of different localities, but there is seldom any adjustment of premiums to these differences. Moreover, such an adjustment would be extremely difficult, since a life-insurance contract is a long-term contract, there is no guarantee that the insured would remain in the same occupation he was in at the time of insurance, there would be a very great difficulty in controlling the change of occupation, and the effort to adjust rates to change of occupation would not meet with favor of the insured. An insurance company operates on a basis of a certain mortality table. Risks are either accepted or not accepted. The rates are conservative and safe, because the mortality assumed from the table exceeds the mortality which may be safely expected. In a mutual company the savings due the difference in mortality may be returned to the insured as dividends.

In comparison with life insurance, the problems presented by health insurance are extremely complex, if it is desired to apply the strict rules of actuarial science. This would be necessary if voluntary long-term contracts were made. The arrange-

ment would not be safe unless there were a true balance between payments and the cost of benefit. The difficulties are statistical rather than actuarial—i.e., the mathematical rules are available to handle the underlying facts, but the information as to the facts is very scanty.

The benefits which must be paid under the system are numerous. Data as to frequency of sickness and non-industrial accidents, according to the age and occupation, would be necessary; also the distribution of cases of sickness and resulting disability by duration of the case, according to both age and occupation. The valuation of the maternity benefit requires data as to frequency of childbirth among the women of the wage-working class. The funeral benefit, no matter how small, raises all the technical problems of life insurance. Finally, the broad plans of medical and surgical aid, hospital care, and the supply of drugs and appliances raise many questions as to the amount of aid which will be necessary and its probable cost. Granted all this necessary information, it would be possible to compute a proper rate to be charged at each age of entry into insurance. But the plain truth is that for most of these problems such information is unavailable and may remain unavailable for a long time, and any actuarial computations made are likely to be very uncertain.

It is true that the work of the British National Insurance Committee gives the semblance of such

accuracy and security. In the tables all data are carried out to the third decimal place. But as a matter of fact, this accuracy is illusory only. It was characteristic of life-insurance actuaries that, while punctilious care was taken of all age differences, occupational differences were disregarded. Were all the 14,000,000 British insured members of one large fund, this disregard of occupational differences might be inequitable, but would not disturb the actuarial soundness of the scheme. But since the thousands of approved societies are financially independent of one another, fluctuations in results between the societies must soon develop. In fact, it developed very soon¹ that the fluctuations of sickness frequency are so great as to promise substantial surpluses in some societies, and to threaten deficits and bankruptcy in others. While all the government calculations were based upon an actuarial estimate of 1 week's sickness per member per annum, during the very first six months of application of the act, 15 selected societies with a membership of 187,000 showed together an average sick rate of 1.06 weeks; but 7 male societies showed fluctuations in the sick rate from 0.68 week to 1.3 weeks, societies with mixed membership from 0.85 to 1.74 weeks, and female societies from 0.58 to 3.15 weeks per member per annum. Even larger fluctuations of cost were reported to the Departmental Committee on

¹ *New Statesman*, Dec. 6, 1913; also, Special Supplement to issue of March 14, 1914.

Sickness Benefit Claims² and while explanations are sought for in the possible differences of administration of the act by numerous more or less independent societies, obvious reasons are found in the differences of localities, age distribution, and occupation. Especially is the latter factor of importance. It is reasonable to assume that in the various societies organized by the Prudential Insurance Company the general administrative tendencies are fairly uniform. Yet, to quote only one striking illustration, "in the General Women's Society the payment per member per week (for sickness benefits) is 3*d.*, but in the Domestic Servants' Society the cost falls to 2*d.*, and in the Laundress' Society it rises to 4*d.*"³

The unfairness and actuarial complications arising from uniform rates in view of such differences in experience are obvious. Of course triennial valuations, provided for in the law, furnish a means of correction by reducing the benefits, but this preservation of the solvency at the expense of the quality of service is not a very desirable situation. The point of view upon which the technical features of the British law are based, that the uniformity of contributions is more important than the uniformity and efficiency of the benefits and service, is an entirely erroneous one. The practical result of this

² See *Report of Departmental Committee on Sickness Benefit Claims under the National Insurance Act, 1914*, pp. 17-25.

³ Report, p. 21.

will be that the benefits prescribed in the law as the minimum standard will cease to be, as they were intended to be, the irreducible minimum of service.

The organization proposed here (as outlined in a previous chapter)⁴ easily and automatically eliminates many of these problems. While full and ample reserves are necessary for a system of insurance based upon voluntary contracts, a compulsory system may consciously adopt an assessment system, under which the amount of funds to be raised annually by contribution is largely determined by the amounts of money to be paid out and expended annually. Since the age distribution of the membership of any large insurance-carrier is not subject to violent fluctuations, the amount necessary is not likely to change very much from year to year. The accumulation and investment of large reserves is altogether unnecessary. Insurance may be divorced from savings. When the system is thus simplified, the true average cost may be ascertained in a comparatively short time. Fluctuations between funds may be looked upon with equanimity so long as they fall within certain reasonable limits, whether owing to differences in climatic conditions or to occupational distribution. It would be expected as a matter of course that a sick fund in a mining or quarrying community would require more money than a large insurance fund for clerical employees only.

The first important deduction to be derived from

⁴ See chap. xii, pp. 196-203.

these observations is that it is quite unnecessary, and in fact very dangerous, to embody any definite rate of contribution in the act. This may be safely left to the individual insurance-carriers to be established by their by-laws, subject to the control of the Commission. This is an important negative standard. In the first few weak efforts at drafting health-insurance bills, the error has already been committed of introducing an iron-clad rate of contribution, sometimes based upon very fanciful actuarial reasoning. It does not follow therefrom that the law may disregard the entire subject of rates of contribution. The general rules governing them may well be embodied in the act. We are now better prepared to reach definite conclusions in regard to the many questions asked above.

UNIFORM BASES FOR COMPUTING RATES

Shall the contributions be at one uniform percentage rate for all wage groups? So far as ordinary sickness benefits are concerned, they are determined as ratios of wages, so that a uniform percentage rate is actuarially just. The cost of medical benefits, hospital care, surgical supplies, and even of funeral benefits, does not bear any proportion to wages. This cost being a constant numerator in the fraction $\frac{\text{cost}}{\text{exposure}}$ of which the denominator is variable (because of wage variations), this cost per \$100

of wages will rise, as the wages decline. The lower-paid wage groups of workers will derive an advantage over the higher-wage groups—a situation which socially is much less objectionable than the reverse would be, since thus automatically, by establishing a simple rule of uniform percentage rates, we really obtain a progressive charge justified by ability to pay.

The problem becomes somewhat more complicated, however, as far as the employer's contribution is concerned, for his contribution would vary in direct proportion to the level of wages paid and he thus would be rather benefited than penalized for a low-wage level. Of course that offers an additional argument for the arrangement suggested^{*} for a sliding scale of contribution for wages below \$9; and it may be utilized for demanding that the sliding scale be moved upward, possibly to \$10 or \$12 of weekly earnings.

It is well to remember, however, that simplicity is a great advantage in these complex acts of social legislation, which must be understood at least in their essential features in order to be popular. A straight percentage rate has the advantage of simplicity, especially so far as the employer is concerned, who can easily ascertain the total volume of his pay-roll, as he must for the purposes of compensation insurance. Moreover, not a small advantage is that this total can be easily and cheaply

^{*} See p. 173.

audited. So far as the contribution of the employee is concerned, the easiest way to collect that is to permit the employer to deduct it out of the contents of the pay envelope. Here for purposes of simplicity employees may be arranged into definite wage groups with a flat contribution for each wage group approximating the stated percentage on an average. For instance, let us assume that according to the by-laws of the local insurance fund 3 per cent of the wages constitute the combined contributions of the employer and employee, 1 1-2 per cent representing the share of each. This will mean 15 cents a week for the employee earning \$10 per week, and 18 cents for the one earning \$12. It would be manifestly easier to establish a rate of 16 cents for all earning \$10 or more but less than \$12 per week than to compute the percentage separately for each pay envelope. The possible combinations are numerous. The act need not be lumbered up with them. But the rule may well be included that the funds may establish such wage groups for purposes of simplifying the computation of contributions, even if the mathematical accuracy of equal division between employer and employed is somewhat disturbed.

AGE AND RATES OF CONTRIBUTION

The rate of sickness steadily increases with age. But since the ideal of true actuarial reserves has

been dispensed with, this factor may be entirely disregarded. As already explained, the British contributions have been calculated at an assumed age of entry of sixteen. Since the introduction of the law found persons at all ages, it was necessary to protect the financially independent societies by providing "reserve values" to compensate for the actuarial loss sustained through a person of higher age joining and paying contributions at the rate calculated for the entry age of sixteen. It is not universally recognized that, while the state assumes the cost of two-ninths of the benefits, the same proportion must be set aside for the purpose of building up the necessary reserve; that, therefore, the entire state contribution is virtually absorbed into such reserves, that this must go on for at least 18 years before the original deficit is met, and that for many years this state contribution is practically unavailable to the insured. Apologists of the actuarial complexities of the British system point to the advantages of building up these reserves, which by accumulating a compound interest will eventually save the British workman about 1*d.* a week, because "7*d.* paid in becomes 8*d.* paid out,"⁶ but it does seem as if this penny was a scant compensation for 18 years of skimping of benefits, which would not have been necessary if the accumulation of reserves were abandoned and the state contribution made immediately available. Since the average age contribu-

⁶ Carr, Garnett, and Taylor, *National Insurance*, p. 99.

tion of a large number of wage-workers will scarcely change from year to year, the uniform contribution for all ages will not embarrass the fund, and any tendency to misstate the age, or to discriminate against the aged, will be eliminated. Lengthening of the school age and general postponement of age of entry into industry may have a certain effect in the long run, but adjustment to all such long-range changes may easily be made when the time arrives.

OCCUPATION AND RATES OF CONTRIBUTION

A more important problem is the effect of occupations upon the sickness rates. The problem has been so thoroughly discussed in American literature in connection with compensation insurance that the justice of some adjustment will be immediately recognized. There is this important difference, however, that in compensation insurance the entire cost is borne by the employer, or the industry, and therefore the responsibility for the hazard is placed where it belongs; while in health insurance an equal part of the cost is placed upon the employee who in no sense is responsible for the excessive morbidity of his trade.

A compulsory provision for adjusting rates of contribution to the occupational morbidity may therefore call forth considerable protest and seem unwise. If a local insurance fund, democratically managed, is sufficiently imbued with the spirit of

equality to establish one uniform rate of contribution for all trades, it would not seem to be wise to place insurmountable obstacles in its way. On the other hand, such uniformity, if it were to be enforced by the law, might lead to some undesirable results. It might stimulate the tendency to formation of numerous trade funds among trades with lower rates of morbidity, so as to enable them to get all the advantages of lower rates of contribution, and thus interfere with the development of large and strong local funds, so necessary for the efficient administration of the medical benefits. Insurance-carriers must therefore be given permission to grade their rates of contribution according to rates of morbidity as shown by actual experience, such grading to be subject to the control of a central administrative body, which is in a position to make the necessary statistical and actuarial computations.

EXCESSIVE HAZARDS

A very potent argument for such grading is found in its preventive possibilities. Notwithstanding the short period of compensation in this country, it has become quite clear that the high rate of insurance may prove a powerful lever for raising safety conditions. This is undoubtedly true of general health conditions as well. For this reason such grading is very desirable, especially in so far as it affects the income account of the employer. This may hold true

of the individual employer or establishment even more than of an entire branch of industry. Schedule rating on fire insurance is intended to provide an individual motive for the improvement of the risk. For the same purpose a very comprehensive system of schedule and experience rating¹ was introduced in compensation insurance. Schedule rating for general health conditions may not be a simple problem, though it does not appear at all impossible. But some method of penalizing extra unsanitary conditions resulting in excessive illness appears very desirable, for the sake of the preventive effect.

Both the German and British acts contain provisions to that effect. According to the new German act, a specially high rate, or even an increase of the share paid by the employer, may be ordered for an establishment suffering from excessive illness. Such measures, if permitted by the by-laws of the fund, may be taken directly by the executive powers of the fund subject, of course, to an appeal to the supervising insurance authorities. By similar provision under the British act, claim for losses sustained through excessive illness may be made, not only

¹ "Schedule rating" is grading of the insurance rate, downward or upward, in consideration of presence or absence of certain safety devices or conditions, or on the reverse, for the absence or presence of hazardous conditions. "Experience rating" is grading of the insurance rate with regard to the actual accident experience of an establishment. See *Proceedings of Casualty Actuarial and Statistical Society*, Vol. I, No. 3, May, 1915.

against employers, in case of insanitary working conditions, but against local authorities, in case of bad housing conditions, bad water supply, etc., and detailed provisions are outlined as to the proper procedure for ascertaining the amount of loss sustained, and recovering such amount. The procedure, however, is cumbersome, semi-judicial, and not as likely to produce the desired results as the direct administrative procedure outlined by the German law.

RESERVE FUNDS

If the theory of rate-making outlined here is adopted, the actual rates in different insurance-carriers will be subject to wide fluctuations, under the influence of differences climatic, sanitary, occupational, and in age distribution, and they will also depend upon the willingness of both employer and employee to extend the sphere of service beyond the minimum limits prescribed in the law. It is intended that the rates therefore be experimental, that the method of changing them be simple; under proper administrative control the danger of financial embarrassment and insolvency need not be serious. Further protection may be demanded by the law in the nature of a small reserve fund, without any intention of making it actuarially accurate and equal to amount of accumulated liabilities, for it is not at all necessary to increase the burdens of the working-man to-day for the purpose of relieving him in the

distant future through the problematic income derived from compound interest. It must not be forgotten that if the level of prices continues to rise and the purchasing value of money therefore decreases then the advantage of compound interest may be altogether nullified by the loss in the real value of these enforced accumulations. A working reserve sufficient to offer a sense of security against the possible effect of a catastrophe or epidemic is all that is required. Such a reserve may be slowly built up by requiring a certain percentage of the annual income to be set aside until an amount commensurate with the size of the fund is accumulated. A reserve equal to the total expenditures of the preceding year would appear sufficient.

LIMITATIONS AS TO RATES

In view of such latitude to be allowed to the funds, perhaps no further reference to the exact amounts of the rates need be made in the law. It is significant, however, that the German law establishes at least some maximum limits. Four and one-half per cent is the normal limit established, and increase beyond this limit up to 6 per cent is permitted only for the purpose of meeting the minimum benefits. A further increase beyond 6 per cent can take place only by concurrent decision of both employers and employees. A little reflection will show the necessity of such limits. Small carriers may have an excessive

expense ratio or may be subject to violent fluctuations of sickness-insurance rates. Exaggerated local pride may prevent necessary consolidations of funds. The wage-workers are required in Germany to carry other burdens of social insurance besides health insurance. A reasonable limitation in the act will facilitate administrative control.

As a matter of fact, however, only in very few cases do these restrictions become necessary, because the actual cost is very much below these excessive limits. In communal health insurance, over one-half of the funds collected only 1 1-2 per cent, about one-fourth from 1 1-2 to 2 per cent, and the remaining funds from 2 to 3 per cent. In local sickness-insurance funds and establishment funds, over one-half of the funds collect from 2 to 3 per cent, and about one-third from 3 to 4 1-2 per cent. The tendency has been all along toward a higher rate of contributions because of the increase in the cost of medical aid and the development of additional voluntary features, but in less than 1 per cent of the funds was it necessary to raise the contribution above 4 1-2 per cent. With the 3 per cent rate the working-man in Germany pays 2 per cent; with equitable distribution his share under the system as outlined above would not exceed 1 to 1 1-2 per cent of his wages—under a \$10 weekly wage, 10 or 15 cents a week; under a \$15 weekly wage, from 15 to 22 cents. However, this aspect of the problem will be treated at greater detail in a subsequent chapter.

XV

ORGANIZATION OF MEDICAL AID

It is impossible, in this brief outline of standards, to devote much space to consideration of administrative details. But although the problem of organization of medical aid is distinctly an administrative problem, an exception must be made in its favor, in view of its tremendous importance, for the successful operation of the entire scheme. In almost all systems of health insurance, medical aid is furnished in kind, instead of by money contributions to meet its cost, as is done in the American compensation practice. This is necessary for considerations of both economy and efficiency. The entire preventive effect of health insurance largely depends upon the successful organization of medical aid.

The most difficult problem during the period of organization of the system in Great Britain and the most scathing criticisms after its institution were all connected with the organization of medical aid. The medical profession in this country is more numerous, better organized, and on the whole wields a greater influence than the profession does in Great Britain. There can be no doubt that so soon as health insurance leaves the domain of pure theory,

and enters the legislative stage, the medical profession will become very much alive to the situation, and will try to influence legislation to suit its own professional views and protect its own legitimate interests. It is necessary, therefore, to determine in advance what form of medical aid is desirable from a broad social point of view, and also what part of the ground it may be necessary to yield to the established customs of the varied elements of the population of the United States.

In order to be able to discuss intelligently this rather specialized problem, it is necessary to indicate briefly the essential problems of medical practice, to which the majority of American students of economics and social science have as yet given very little thought.

The established form of administering medical aid in this country, so far as paid service is concerned, is through so-called "private practice." Medicine is one of the oldest liberal professions, and private practice for a fee is the recognized, time-honored method of performing the service in the liberal professions. As a matter of fact only a few professions have succeeded in preserving this system as a predominating one. While private practice for a fee is still the rule in medicine and law, elsewhere this has given way to the usual contract and stipulated monthly or weekly remuneration. This is largely true of the engineering profession, the teaching profession, theology, most forms of scientific and social

investigation, etc., although in each and every one "private practice" survives to a limited extent, especially in case of the leaders and experts, who may serve in a consulting capacity.

The forces behind this change are not difficult to discover. Private practice gives way as one large employer, either individual or corporate, takes the place of many petty ones. A definite wage contract is preferable because it is both economical and more efficient. There is a better utilization of time, resulting in a smaller cost per unit of service, though the worker's total earnings may increase. Besides, a regular wage contract permits of assignment to special duties, leading to division of labor and specialization such as is very difficult to accomplish under a system of private practice.

The public at large is accustomed to private practice as the normal type so far as the paid practice of medicine is concerned. It has learned to look to institutional treatment by a staff, as a system adapted only to charitable medical aid. The natural consequence is to look to private practice as a more satisfactory, though more costly, form of medicine. Nevertheless, even in this country, the wage-workers of the larger cities have sufficiently demonstrated the economic feasibility of medical aid under some systematic arrangement between a body of prospective patients and the physician.

The first practical question that must confront the constructive social legislator in approaching this

problem is this: Can medical aid, on the broad lines indicated above, be given without some change in the customary conditions of private practice? That is, are these conditions fully adapted to the needs and means of the working class?

An answer to this question may be found in the present status of medical aid to the workers. Because private practice is expensive, even though the scale of fees for physicians practising among the poor is comparatively low, medical aid is not sought except as a last resort. There persists a harmful tendency to self-medication, a popularity of injurious nostras, or a plain neglect of chronic ailments. Medical aid among the poor is largely inefficient. It is administered almost exclusively by so-called "general practitioners" or "family physicians," often Jacks-of-all-trades, whose persistence is out of all harmony with the recent phenomenal development of scientific medicine. There is perhaps a distance of a quarter of a century between the present status of medical science and that of medical practice among the poor. Conditions of private practice among the poor do not offer an inducement to careful examination, to study, or to the application of modern methods. There is no doubt that conditions of dispensary practice—at least in first-class public dispensaries—are very much superior because they offer expert advice of specialists and possess the necessary modern equipment. But dispensary practice is largely limited to ambulatory patients, is

placed on a basis of charitable relief, and therefore has serious drawbacks of its own kind.

It might be argued that the creation of a large fund for the treatment and relief of all workers could improve these conditions without necessarily disturbing the underlying basis of private practice. This is entirely conceivable. To some extent it is the condition prevailing in the practice of accident compensation, since most American acts impose upon the employer (or the insurance-carrier) the duty of paying for the necessary medical aid, instead of requiring that such aid be furnished in kind.

But there are very serious objections to such a system. The first consideration is that of economy. In compensation the cost is borne by the employer, who presumably is able to bear the high cost of medical aid. Some 20 to 25 per cent of the cost of accident compensation in this country is consumed in physicians' bills. Yet, though the injured workmen do not directly pay the bills, they suffer from their excessive scale, because the amount of medical and surgical aid to be given is entirely too closely limited in most states, mainly out of fear of the excessive charges of private physicians. In health insurance the workers themselves bear a large share of the burden, and strict economy is more urgent. Disorganized medical aid is uneconomical just because of this lack of organization. Excessive cost of the unit of service does not at all spell excessive income of the practitioner because private prac-

tice is hopelessly tied up with loss of time for the majority of the practitioners. The unsuccessful ones barely make a living, though charging from \$1 to \$2 for a few minutes of work. The successful ones must grow hurried and careless in their work, since their income is in adverse proportion to the time and care they are willing to give to the patient. Besides, the broad effect of prevention of ills is almost altogether lacking in private practice; medical control over those who are ill, or those who claim to be, is made very much more difficult; malingering is directly stimulated.

If some sort of organization therefore seems clearly indicated, the exact lines on which it must proceed are still subject to many fluctuations. Complete organization would presuppose a state of affairs in which all the medical work to be done for the members of a health-insurance fund would be done by physicians and surgeons (one or many, as the case may be) who are specially employed for the purpose and devote their entire time to it, as is the case with the internes in hospitals and in other institutions. That is not at all a revolutionary proposal. It exists in many industrial corporations, it is found on a national scale in the famous system of Russian village medicine, and often gives excellent results. It is in use in some German health-insurance funds and is advocated by many experts on health insurance and by a goodly proportion of administrative officers of health funds.

It is sometimes advocated even in this country by persons familiar with the advantages of organized medical service in the army or navy, for instance. It finds its support occasionally in the brilliant results achieved by thorough organization of medical service in the building of the Panama Canal.

But this entire elimination of private practice among members of a health-insurance system has raised very strong objections from two sources—the medical profession and the insured themselves. The physicians are opposed to such complete organization because they fear that in its place will be found for only a limited portion of the profession—which seems to be based upon an assumption that the medical profession is already overcrowded. It is true that the census indicates some 150,000 physicians in the United States or 1 physician to a population of some 600. Yet it is difficult to say whether this proportion is excessive. There are many idle physicians, but there are also many overworked ones, and many ill persons who do not receive adequate medical aid.

One of the most significant results of the *Community Sickness Survey* of a middle-sized city undertaken by the Metropolitan Life Insurance Company¹ was the statement that only “61 per cent of the cases of sickness had a physician in attendance,”

¹ *Community Sickness Survey*, Rochester, New York, Sept., 1915, by Dr. L. K. Frankel and Dr. L. I. Dublin. *United States Public Health Reports*, Feb. 25, 1916.

and that "only 45.3 per cent of those sick but able to work had physicians in attendance," while, "of those both sick and incapacitated for work, 63.8 per cent employed physicians or were being treated in institutions." If, therefore, nearly two-fifths of the sick poor receive no medical aid, it becomes obvious that through a system of health insurance the amount of medical aid to be furnished would at once increase very materially. Perhaps a very rough computation may be made here for purposes of illustration only. If the average annual number of sick days per adult person is about 10, a population of 600 will give some 6,000 days of illness, or some 20 patients per every working day for each physician, perhaps as many as one should be required to care for. But in every civilized community the number of physicians required for the work of control, of investigation, of public health and hygiene is growing fast, so that the foregoing proportion of physicians to population is probably higher than will be found in actual practice. It is significant that while the proportion of physicians to population is higher in the United States than perhaps anywhere else in the world it has not increased during the last fifty years, and during the last decade, because of the raising of educational requirements for the study of medicine, and the consequent rapid reduction in the number of medical schools, the proportion of physicians to population in the

United States is actually decreasing. Moreover, no system of health insurance contemplates the inclusion of the entire population, and among the higher social strata private practice with its higher fees and greater income and leisure for the medical practitioner may still persist. Be it as it may, the interests of the physicians—an important, powerful, and intelligent element of our population—cannot be disregarded, especially as regards those who are already in practice. If the profession, however, be already overcrowded, a situation which would bring that fact to light and prevent excessive increase in the future is of itself not an undesirable one.

Another serious objection which is advanced by the medical profession is that complete organization of medical practice would lower the standard of medical income and would close the avenues for advance to the ambitious members of the class. This argument can be very readily disposed of. High medical incomes are very few and far between. They are found almost exclusively among the fortunate few who are ministering to the ills of the wealthy. In practice among the poor, large incomes can be achieved only through exhaustive overwork or by gross neglect of the interest of the patients. The difficulty is that the psychology of the medical man has been adjusted to a speculative hope of exceptional success, a factor wholly absent in most other liberal and scientific professions, and one which fre-

quently has an injurious effect upon the entire psychology of the profession and its attitude of the average physician to social problems.

FREEDOM OF CHOICE OF PHYSICIANS

A quite different line of defense of private practice is advanced by the general public, namely, the necessity of freedom of choice of physician because of the intimate relation existing between physician and patient and the necessity of complete faith in the selected healer as a prerequisite to successful treatment. That is a force to be reckoned with. A measure of social amelioration cannot be successful if it runs directly opposite to the wishes and sentiments of the beneficiaries, no matter how ill grounded such sentiments may be. Nevertheless, in planning for large measures the effect of which will mainly manifest itself in long-range changes, it is proper not to accept these wishes and sentiments as final and conclusive. Of course the advantages of such freedom of choice are often imaginative or even illusory. Moreover, social and economic conditions have already abolished free choice in a great many instances. It does not exist in thousands of smaller communities where there is no choice. It is not expected in hospitals and dispensaries to which literally millions of workers and their families apply for medical aid. It is but seldom exercised in regard to selection of specialists when the suggestions of the

family physicians are accepted. It is waived, so far as the individual members are concerned, in a large number of fraternal lodges, after the selection of the physician has been effected by a democratic vote.

Scientifically, the advantages of a free choice are open to criticism. They may have been great so long as the function of a physician was exercised largely by moral suasion. But scientific diagnosis, serotherapy, and skilful surgery do not depend for their success upon such whimsical considerations. In large industrial communities the poetic "country doctor," who took care of several generations, has long since given way to the modern commercialized practitioner. It is preposterous to imagine that the average working-man or woman, altogether ignorant of even the elements of physiology and hygiene, is able to pass intelligent judgment upon the professional accomplishment of his physicians. But because professional success sometimes depends much more upon the physician's reputation in the community than upon his professional standing among his colleagues, the free choice of physician is often defended because it represents a valuable asset, comparable to the "good will" of commercial undertakings. The constructive legislator, therefore, need not perhaps be intimidated by the intrinsic value of free choice, but he must reckon with it as a social force which cannot be antagonized too strenuously, since the success of the whole plan of health insurance is involved.

The practical conclusion, therefore, seems to be that medical organization is to be aimed at so far as conditions will permit, but that in deference to existing conditions certain freedom of choice among physicians must be provided for. But shall this freedom of choice be limited to the physicians who have entered into a contractual relation with the fund, or shall it be extended to the practitioners of medicine generally? European experience offers a variety of expedients. In Denmark, the law does not undertake to regulate the conditions of medical aid. In practice, all forms are found, from assignments of physicians to definite districts, to freedom of choice of any physician. Yet the last method is rare, and the prevailing method is either the designation of a district physician, or the right of choice between a limited number of physicians employed by the fund. In Germany, the recent law of 1911 demands the freedom of choice between at least two physicians "if it does not add excessively to the cost," with the important limitation that all medical aid must be furnished by physicians under contract. Here, also, practice has created both types, while the question of comparative advantages of the physician employed outright and selection from a large list of physicians still remains one of the mooted questions in the practice of German social insurance.

The question of local option in regard to organization of medical aid has been approached by the British Health Insurance act in an entirely different

spirit. The national act prescribes a system which is practically uniform throughout the land. The system was decided upon as a compromise after a stormy conflict with the medical profession. The resulting system of "medical panels" (or registered lists of physicians) grants the right to practise among the insured for a stipulated annual amount to each reputable physician. The right to practise among a certain class of population is therefore recognized as a vested right of the profession and of all the members of the medical profession.

Sufficient evidence has already accumulated to prove that the British system does not work out well in many particulars as far as the treatment of disease is concerned. It has left the entire choice in the hands of the individual workman, and preserved the economic dependence of the physician upon the good will of his clients. It has placed no limits upon the number of insured patients a physician may have, and has therefore stimulated low-grade competition among physicians for the capture of the largest possible number of contract clients. It has limited the insured practically to one physician, and made treatment by specialists unavailable. In short, though it has increased largely the amount of medical advice given, it has not succeeded in improving its quality. Cases are reported in the Fabian report of physicians who have as many as 9,000 insured on their lists and who are forced to hire one

or more assistants in order to give them even the most superficial treatment.

There is very important warning in the English conditions of what the worst abuses are, which must be carefully avoided. Any one who is somewhat familiar with the conditions of medical education and the legal requirements for practice in this country knows that variations between the highest and lowest standards are such that in some states neither a medical diploma nor a state license is a sufficient guaranty of efficiency. There is absolutely no reason why a health-insurance institution, with the means at its disposal, should renounce the right to intelligent selection of its medical practitioners according to standards established by competent authorities. There is no reason why it should permit the commercial spirit of some practitioners to interfere with the efficiency of the campaign of health preservation which in the long run will be the most important aspect of the insurance system.

Yet it is quite evident that no organization of medical aid can be effective from the point of view of public health, in which the legitimate interests of the medical profession are not taken into due consideration. It is not only that a certain amount of good will between the physician and patient is after all essential to successful practice of the medical art, but that the development of medical science and its successful application by skilful hands is impossible without a fairly prosperous, satisfied medical

profession. This does not contemplate the phenomenal incomes made by the fortunate few. But while exact information as to the economic status of the medical profession in this country is lacking, the very fact that statements as to the average income of physicians, varying from \$600 to \$1,200, are frequently mentioned and accepted with credulity seems to indicate an unsatisfactory condition for many.² Evidently satisfactory progress of medical science and the art of medical practice cannot be built upon such an economic basis. A prosperous, rich people is entitled to a medical profession sufficiently relieved of the struggle for existence, to be able to command some leisure from work, and to devote part of that leisure to its own development. For medical science is at present, perhaps on the height of its development, and no amount of school education alone can long keep the practising physician abreast of the times unless supplemented by continuous study of the results of scientific advance.

The proper organization of medical aid is, therefore, closely connected with the complicated problem of remuneration for medical work. It is charged by many, for instance, that the shortcomings of the British system, repeatedly referred to above, depend largely upon the unsatisfactory provisions for pay-

² The Social Insurance Bureau recently established by the American Medical Association, the work of which is in charge of the writer, contemplates collection of accurate data on this subject.

ment to doctors. It is true that the question of rate of payments to physicians was the cause of serious contention between the central authorities of the national health-insurance system and the organized medical profession in Great Britain,³ and that in various German cities it has led to serious conflict between the insurance funds and the physicians, often accompanied by the so-called "doctors' strikes,"⁴ of which as many as 1,022 were recorded up to 1911, with 921 decided in favor of the doctors. This result alone would indicate that usually the medical profession had real grievances to contend with.

There is reason to believe, however, that the financial organization as here outlined is much more favorable to the prevention of such unseemly conflicts. In Great Britain the iron-clad system of contributions, definitely fixed in the law, made a more liberal treatment of the physicians a problem of great financial complexity. In Germany the parsimonious attitude of the working-men to their doctors may be easily explained by the fact that these wage-workers contribute 66 2-3 per cent of the total cost, and therefore are jealous of every increase of expenditures. But under the plan here outlined the wage-workers would be financially responsible for only 40 per cent of any increase in the cost of medical aid.

³ See "Report for 1912-13 on the Administration of the National Insurance Act," Part I (*Health Insurance*), pp. 124-58.

⁴ See I. G. Gibbon's *Medical Benefit*, especially pp. 227-46.

As is shown in the following chapter, the average cost is computed at 3 to 4 per cent of the wages, of which some 1 per cent to 1.5 per cent will represent the cost of medical aid, if the Leipzig basis is assumed. Supposing extreme liberality were displayed to the medical profession, an increase of the cost by some 50 per cent or to 1.5 per cent or 2.25 per cent of the wages would probably be the extreme outside limit of this result. The additional .5 to .75 per cent of the wages would represent as far as the employee is concerned from .2 to .3 per cent of wages, or, with an average wage of \$600, from \$1.20 to \$1.50 a year. Even for the worker with earnings of \$1,000 the excess would be about \$2 to \$3 per annum. Surely an efficient medical service is worth this additional charge. It is impossible to go into the details of this problem at this place.*

A great many different plans are operative in Europe. The simplest method is that of exclusive employment at a stipulated annual salary. At the other extreme is a scale of definite fees for visits, operations, and all other forms of medical service. The British system has adopted the capitation plan, which represents a sort of crude insurance contract between physician and insured, since the former agrees to furnish all medical aid throughout an entire year for a small consideration. It would seem to be very much wiser if this function of insurance were lodged

* Perhaps the best discussion of this may be found in *Medical Benefit in Germany and Denmark*, by I. G. Gibbon.

in a fund rather than in an individual physician whose remuneration, unless on a salary basis, were better adjusted in some proportion to the service rendered. Yet since the measure of the necessary service remains largely with the physician, a fee schedule, no matter how moderate, offers a constant temptation to excessive visits and bills. To counteract this tendency different schemes have been tried out in different funds. In Leipzig, e.g., a definite per capita charge is assigned to the entire body of physicians in a panel, to be distributed among them in proportion to the work done, which creates among the physicians themselves a controlling force to prevent any one from claiming an excessive share. The whole problem may be said to be still in the experimental stage, and there is no necessity to embody iron-clad rules into the law, or to make them uniform for the entire state. So long as the central authority is given sufficient power to control the situation, time may be depended upon to bring out the best methods adapted to any community. The aim to be emphasized in the law is the quality of the service, rather than the details of remuneration, which, in the beginning at least, may be left to the combined efforts of collective bargaining and government regulation.*

Discussing, as we are here, broad legislative standards, rather than details of actual administra-

* An authoritative discussion of this question by Dr. Alexander Lambert, of New York City, will be found in Appendix 2, p. 295.

tion, the same rule would seem to hold in regard to the entire problem of organization of medical aid, especially if these standards are intended for the country at large rather than one specific state. The Mills Bill introduced in New York, and the identical bills of the American Association for Labor Legislation introduced in other eastern states, was severely criticised by some physicians because the drafters failed to work out all these details and embody them in the law.⁷ The omission, however, was intentional and based upon these considerations:

First, no one knows what the most acceptable form of organization both for the physicians and patients would be, and principles once embodied in the language of the law are not easily changed.

Second, it is extremely doubtful whether the establishment of one uniform iron-clad system is at all desirable. Even among the physicians an extreme divergence of opinion exists.

It would seem very much better to leave a good deal of latitude, especially in the beginning, so that various plans may be simultaneously adopted and tried out.

ORGANIZATION OF DRUG SUPPLY

In the organization of the distribution of medical and surgical supplies and other apparatus parallel

⁷ See especially *Medical Economist* for March, 1916, Vol. IV, No. 3, p. 59.

problems may arise, but they appear to be very much less complicated. With the exception of drugs to be specially compounded, we are dealing here with well-standardized articles of commerce which can readily be bought in the open market. The problem is analogous to that of the consumers' co-operative movement, whose very soul is wholesale purchasing and elimination of the middleman's profits. There is a very potent argument, therefore, for direct distribution of such supplies, at least by the larger health-insurance funds. The compounding of prescriptions, however, has become a recognized profession and as such it succeeds in wielding a definite social influence. From this there has resulted a curious pressure for freedom of choice of druggists, as if drugs, like medical advice, depended for their efficacy upon personal confidence of the consumer.

The one serious difficulty about direct assumption of the drug and supply business by the sickness-insurance carrier is the local character of the druggist's trade and the necessity for emergency service, which in large cities may make central distributing stations somewhat inconvenient. In Germany the peculiar laws in regard to the licensing of druggists and drug-stores have strengthened their position to such an extent that the new act of 1911 practically guarantees them their vested interests in the business, with freedom of choice, and the funds may make contracts only for the limitation of charges. In

Great Britain the consideration for the economic interests of the pharmaceutical profession went even farther, so that druggists' panels were established by the insurance commissioners practically on their own initiative. The complicated English arrangements may be justified by the fact that the societies are not organized in territorial limits, and their territories overlap, but where geographically limited funds prevail, the methods of drug distribution can be materially simplified. The health-insurance act may well require all large funds, with over a certain membership, to establish a direct supply of all therapeutic and surgical materials, with the exception of emergency prescriptions. It must, at least, not contain any provision which will prevent the development of such co-operative initiative. Through such economical administration, all arguments against the supply of rare and expensive drugs or apparatus may be answered.

ADMINISTRATION OF INSTITUTIONAL TREATMENT

So far as institutional treatment is concerned, definite rules in the law would appear premature. Undoubtedly the goal to strive for is the upbuilding of special hospitals, sanatoria, and similar institutions by the health-insurance funds, wherever real need for such additional facilities exists. All this, however, will require accumulation of both the necessary funds and experience. Contractual agree-

ments—also under the control of the insurance commission—will be the predominating method in the beginning. The appearance of a large body of paying hospital patients will stimulate the development of both private and public institutions. A sufficient period of time for the necessary transitional stage must be allowed, but eventually a certain number of beds in proportion to the number of insured must be demanded by the law. In combination with private benevolence and public health service the growth of hospital facilities must be developed until institutional treatment for all cases requiring it will become a matter of course.

Since the advantages of institutional treatment for certain cases are well recognized, at least in the more civilized communities, and since the development of hospital facilities at least in such communities is very much more advanced than in English cities, no such fiasco as has as yet accompanied the so-called sanatorium benefit of the British law need be expected. In less fortunate communities the insurance law itself, not being cramped by the iron-clad limitations of a fixed income, could easily develop such hospital facilities.

There is, however, one somewhat peculiar medical institution which perhaps has scarcely anywhere developed to such high extent as in some of our larger cities, and that is the so-called dispensary, or out-patient clinic, operated usually in connection with hospitals, but sometimes independently, which raises

a great many important questions of administration and even organization.

An outpatient clinic, popularly known as a dispensary, is an institution "for the proper treatment of the sick who are too poor to pay for medical advice and treatment, and are not eligible for admission to hospitals."⁸ How well at least quantitatively these institutions meet the need in our large cities may be surmised from the fact that in New York City, for instance, there were in 1914 130 such institutions, treating literally millions of patients. As far as ambulatory treatment is concerned, no poor working-man, who can spare the time and sometimes the dime, need to go without it.

It may be argued, therefore, that in such cities, at least, the problem of medical aid for the poor is largely met. On the whole this is perhaps true, at least in regard to less serious ailments. Nevertheless, the dispensaries are often criticised and by some are even considered an evil.

The masses often criticise these institutions for the crude, and even cruel, way in which patients sometimes are treated. The charge to a large extent represents the exaggeration of supersensitive patients, but it is admitted that frequently because of pressure of work the patient is not treated with the same courtesy as a private patient in the physician's private office would have the right to expect.

⁸ *The Associated Outpatient Clinics of the City of New York, Second Annual Report, 1914, p. 5.*

More serious is the economic aspect of the case: dispensaries after all are charitable institutions; they are intended for the poor; persons there attended are technically on a par with paupers. There is a factor there which deters some from applying to dispensaries for aid.

On the other hand, dispensaries are sometimes characterized by the medical profession as an evil because of the abuse to which they are subject, mainly because, it is energetically charged, they offer free treatment to patients of a class to whom the payment of a regular fee would not be impossible. The average practitioner among the poorer classes, therefore, fears the dispensary as his greatest competitor for the paying patient. The war between private practitioners and dispensaries, which has been going on to the writer's knowledge for at least twenty years, is not devoid of its humorous aspects. From the controversial literature on this subject, one might assume that the struggle lay between two groups of practitioners of medicine. As a matter of fact, the persons on both sides of the trenches are largely the same. The private practitioner who kicks and rails against the dispensary which takes away his patients is frequently the same practitioner who at certain hours of the day does the very selfsame dispensary work.

The reason for this is not difficult to understand. A certain number of physicians are forced by economic pressure to take up the practice of medi-

cine immediately upon graduation when their practical knowledge and experience are slight. The dispensary offers a valuable school for the necessary, practical experience. Others more fortunate, having tried a course in the hospital as well as in school, feel that they must keep in touch with things lest they lose hold on the knowledge and experience acquired. In other words, dispensaries attract for the same reason that hospitals attract. In addition there is the possibility of finally gaining a hospital appointment by faithful service in the dispensaries. And finally, to the young physician without any ties or valuable connections, the dispensary offers the only available method of getting in touch with prospective patients, a sort of mild advertising, but the only kind permissible by the rigid code of medical ethics. The physicians, therefore, continue clamoring for dispensary appointments, at the same time railing against the increase in dispensary work.

The situation thus appears sufficiently complex. But it is further complicated by its most peculiar feature: with very few exceptions the work is done in the dispensaries by physicians without any financial consideration, which is also true of hospitals, of course. It is assumed that, dispensaries and hospitals being charitable institutions, "virtue must be its own reward." As far as hospital wards are concerned, the standing acquired by the physician through an appointment, and the material advantages of a hospital connection in the competition

for medical practice, are so great that perhaps the question is less important. But the enormous free work of struggling physicians in the charity dispensaries is certainly an anomaly not found in any other professional activity.

The fact often mentioned as a justification, that the physicians obtain in the dispensary valuable experience, is no answer at all, because experience is gained through work in any profession, and that may be a reason for lower pay, but not for gratuitous work. The rules of apprenticeship cannot apply to men and women who must be about 25 years or over when beginning the practice of their trade. It has always seemed to the writer that a concerted movement among physicians to demand pay for their work in the dispensaries would have made the atmosphere in these institutions much more healthy.

The discussion was undertaken because of the close bearing the problem has upon the organization of medical aid. If, technically, the dispensaries are intended for persons unable to pay for medical aid, and if the system of health insurance would undertake to furnish such medical aid, this would technically eliminate millions of wage-workmen from the category of persons entitled to dispensary treatment. If, as is likely, and has been urgently advocated here, the medical benefit is extended to the members of the insured's family, the inroad into the clientèle of dispensaries would be so great as to make many of them unnecessary.

But yet dispensaries, because of their technical organization, if not economic basis, have evident medical advantages:

First.—They permit of an economical utilization of the physician's time.

Second.—When properly organized, they have a serious advantage of proper equipment, which in modern medicine and surgery is a matter of no small moment—to mention only such facilities as chemical laboratories, facilities for blood analysis, bacteriological laboratories, spectrosopes, X-ray apparatus, electrical appliances for treatment, and so forth. It is impossible for a private physician, practising among the poor, to have an office so thoroughly equipped.

Third.—The dispensary presents the very great advantage of combining the services of experts in all the numerous specialties, which gives the patient the possibility of a collective advice. It has been repeatedly pointed out by modern writers that no one physician can undertake even to make the diagnosis of a complicated ailment, let alone prescribe or administer the treatment.

Since these advantages are important, and since efficiency of medical aid must be an essential feature of health insurance, shall dispensaries be permitted to stay outside for the benefit of uninsured paupers only, or can they be absorbed into the health-insurance system, without further exploiting the unpaid labor of a numerous profession in the work of destroying their opportunity of making a living?

This is a serious problem in organization and

administration. A health insurance system which undertakes to do justice to the wage-worker, and to free him from the stigma of pauperism, cannot build its success upon the further exploitation of a profession. Evidently the free treatment of insured would be unfair, and especially so the unremunerated labor of physicians in granting the treatment. But assuming that all the work of the physicians is reasonably remunerated, it would seem to be reasonable to permit dispensaries to practice on equal terms with individual physicians. It is possible that under such circumstances the ordinary cases will gravitate to the private physicians, for, after all, privacy is a characteristic much sought for in the relations between physician and patient, while the cases needing the facilities of the dispensary will gravitate to them, perhaps frequently under the advice of the private physician. This is at least a possible development. Its realization cannot be accomplished through legislative mandates. But the standards of health insurance may well include the permission to make arrangements for treatment of patients with dispensaries, for reasonable pay, provided the work of the physicians is paid for at rates satisfactory to the medical profession.

XVI

ESTIMATES OF COST

WHEN the health-insurance bill of the American Association for Labor Legislation was discussed in New York wildest guesses as to the cost of the bill, or of any system of health insurance, were made. It is definitely known what the British system costs, because the contributions are definitely fixed. The system outlined here is based upon the fixity of benefits, and contributions adjusted to the cost. Still this but follows the German system, and it is known that the German funds seldom call for more than 4 1-2 per cent of the wages. It is true that the cost of the German system has been gradually increasing: For one thing, the benefits have increased, partly by law and partly by voluntary action. But taking the local sick benefit funds, which are the predominating type and claim over one-half of all insured, in 1888 some 39 per cent of the funds collected dues equal to 1 1-2 to 2 per cent of wages, and 46 per cent 2 to 3 per cent of wages, so that for 85 per cent the dues were between 1 1-2 and 3 per cent. This combined proportion held true in 1898, though the proportion of funds with dues of 1 1-2 to 2 per cent was reduced to 26 per cent and that be-

tween 2 and 3 per cent increased to 60. By 1908, only 10 per cent had dues of 1 1-2 to 2 per cent, and 55 per cent dues from 2 to 3 per cent, but meanwhile the number of funds with dues below 1 1-2 per cent became very small, and that with dues from 3 to 4 1-2 per cent increased to 31 per cent. According to the latest available data for 1912, the percentage of funds with dues from 1 1-2 to 2 per cent has further decreased to 8 per cent, and those with dues from 2 to 3 per cent also decreased to 50 per cent, while the number of funds charging from 3 to 4 1-2 per cent increased to 37 per cent, and there were 2.7 per cent with rates over 4 1-2 per cent. A similar development was observed in funds of all other types, as the following table demonstrates:

RATE OF DUES IN 1912

	1-1½%	1½-2%	2-3%	3-4½%	4½-6%
Communal insurance	48.9%	24.5%	26.6%	—	—
Local sick funds.....	1.3"	8.4"	50.6"	37.0%	2.7%
Establishment funds	6.8"	11.7"	49.1"	29.5"	2.9"
Minors' funds	5.8"	21.1"	46.6"	25.1"	1.4"
All funds	21.5	16.2	40.8	19.8	1.7

It must be remembered that the German sick-benefit funds also cover the first 13 weeks of all industrial accidents.

There is very little justification, therefore, for the estimate of the Mills Bill made by the Board of Trade and Transportation of New York, that the

cost might reach \$180 per annum for a wage-worker earning \$1,000 a year.¹

The academically trained mind would be satisfied with the statement of the cost in Germany, as an approximation. But the attitude of the American mind must be reckoned with, which rejects all such guesses based upon analogy with foreign conditions. No matter what the subject of the comparison may be, the same objection is immediately raised that "our conditions are different from those of monarchic Germany," etc. The writer has no doubt that even an actuarial deduction will be rejected upon the same convincing ground that the Germans believe in the Kaiser while we believe in the Declaration of Independence, and, therefore, their figures cannot apply to us.

An independent effort at a computation, therefore, appears preferable.

The probable cost of the insurance system proposed here cannot be guessed offhand. If it were necessary to compute the actual rates for different trades and localities in advance, the problem would be still more difficult. But in the face of all these statistical and actuarial difficulties, some estimate as to the probable cost, in its relation to the wage-earner's paying capacity, appears quite necessary, lest the program outlined appear altogether extravagant and visionary, and be forthwith dismissed

¹ Pamphlet under title *Would Cripple Employers*, etc., issued by the Board in March, 1916.

as such. With apologies for the crudeness of the methods used, an estimate of the cost is here undertaken. It will be remembered that the benefits have been divided into four large groups: sickness benefits, medical aid in the broadest sense, maternity benefits, and funeral benefits. A separate estimate as to the cost of each will be required.

An estimate as to sickness benefits is comparatively simple, because they depend entirely upon the average sickness rate, expressed in number of days per annum. For the entire German system, the average has risen in 30 years from less than 6 to more than 9. The increase was partly due to the extension of the minimum period of assistance from 13 to 26 weeks in 1903. The experience of 18 years (1888-1905) for the Leipzig fund indicates about 9 days per annum, but within recent years it has risen, being 10.4 days in 1912 and 11.3 days in 1913. The experience of the Manchester Unity indicates (if illness for 26 weeks be included) a rate of 0.838 weeks or 5.9 days at the age of twenty; rising with age until at fifty-five it amounts to 1.634 weeks or 11.3 days. The average for the age group twenty to fifty-five is about 7.4 days. This is a male table, subject to some selection and therefore rather too favorable for a universal compulsory scheme. An average of 10 days or 1.43 weeks therefore seems quite conservative and safe. At the rate of 66 2-3 per cent of the wages as a benefit, the cost of this benefit per annum will represent 0.9538 of one week's wages or, on a

basis of 50 weeks' wages, 1.908 per cent of the annual earnings.²

The system outlined here provides a weekly benefit, akin to the sickness benefit, in case of childbirth, to the wage-working woman, such benefit to extend for some definite period, say 8 to 12 weeks. The "rate of issue" varies with the age of the married woman; with the age of the husband; with the duration of the marriage; in this country, as in most others, with the number of previous children. Disregarding all these refinements, however, it equals, according to the data of the British actuaries, about 15 per 100 wives. The weekly sick benefit in each case would be (within the limits of 8 to 12 weeks) from 5.336 to 8.004 weeks' wages.³ If employed married women alone were to bear this cost, it would amount to from 1.6 per cent to 2.4 per cent.⁴ Since, however, married women constitute only about 15 per cent of all the women gainfully employed (in manufacturing pursuits only 12 per cent, in trade and transportation less than 7 per cent), the cost of this benefit if distributed among all women would be only 15 per cent of the foregoing amount—only 0.24 per cent to 0.36 per cent of the annual earnings. If, as it should be, the cost be distributed among all insured, irrespective

$$^2 1.48 \times .667 = .9538$$

$$.9538 + .50 = 1.908$$

$$^3 .667 \times 8 = 5.336; .667 \times 12 = 8.004$$

$$^4 5.336 \times .15 + .50 = 1.6\%; 8.04 \times .15 + .50 = 2.4\%$$

of sex, on the theory that maternity for the purposes of the insurance system is only one of many different forms of physical disability, then the cost of the maternity benefit to working-women becomes so small as to be hardly worth considering—from 0.048 to 0.072 per cent of the wages.

The funeral benefit is a flat charge irrespective of wages. It might be made a variable amount, proportionate to wages, but it scarcely seems necessary to do that simply for purposes of actuarial computation. The average mortality rate in this country is about 16 per 1,000. In absence of better data one may be excused for adopting for purposes of this crude computation the standard size of a family as 4.6 persons. The average rate of mortality per standard family, therefore, is 73.6 per 1,000 families. In 1900, according to the latest data available, there were 17,430,000 persons employed in personal service, trade, transportation, and manufactures. Of these, 13,520,000 were males, and only 7,455,000 were married men. Of the 3,910,000 women employed in the groups of occupations enumerated, 510,000 were married, but it is reasonable to assume that with comparatively few exceptions their husbands were also employed. Thus we have 7,455,000 complete families for 17,430,000 persons employed, or 42.8 per cent. In addition there were 516,000 widowers and 554,000 widows, altogether 1,070,000 widowed families, or 6.1 per cent. For every 1,000 persons gainfully employed we may assume, therefore, 428

standard families, with 4.6 persons per family, or 1,969 persons; 61 widowed families, for which we may assume 3.6 persons per family, or 222 persons; and 511 persons without conjugal attachments; or a total of 2,702. The average mortality for these 2,702 persons will be 43.2, and the cost of the funerals will be $\$50 \times 43.2 = \$2,160$ or \$2.16 per insured person. Four cents a week should therefore provide the cost of a modest funeral for death in the family. Eight cents will furnish double that amount—\$100. Again, to remain ultra conservative, let us assume an annual wage of only \$500. The cost of a \$50 funeral benefit will therefore amount to 0.432 per cent of the wages.

The cost of the comprehensive system of effective medical aid is perhaps the most uncertain factor in the computation. We have no satisfactory data either as to the amount of skilled medical aid required nor as to the cost of such skilled aid at present, and we are especially in the dark as to the possible lowering of the cost to be expected from effective organization. Nevertheless, some approach to this problem may be permitted.

The Leipzig sickness-insurance fund has as liberal a system of medical and institutional aid as any fund in Germany. On the whole, the standards of medical aid as outlined in the preceding chapters of this study are not essentially superior to those obtaining in the Leipzig fund. We recognize the possible differences in cost per unit of service. Nevertheless,

waiving these differences for the present, the relation between medical and other benefits is worth considering.

The average cost of insurance per member was M. 41.73, or \$9.93, per annum. In view of the dif-

TABLE IV

DISTRIBUTION OF EXPENDITURES OF THE LEIPZIG SICKNESS INSURANCE FUND. ANNUAL AVERAGES FOR 1909-13

	Amount Marks	Per Cent of Total Expenditure	Expense Per Capita* Marks
Medical aid—			
Treatment by physicians..	1,730,254	21.5	8.97
Drugs and supplies.....	885,138	11.0	4.59
Hospital care, etc.....	774,481	9.6	4.02
Total medical aid.....	3,389,873	42.1	17.58
Sickness benefits to members	2,288,720	40.9	17.06
Sickness benefits to dependents	185,913	2.3	.96
Reimbursement to third party for sickness benefits paid..	152,958	1.9	.79
	3,627,591	45.1	18.81
Maternity benefits.....	160,606	2.0	.83
Funeral benefits.....	174,365	2.2	.90
Administrative expenses....	696,059	8.6	3.61
	8,048,494	100.0	41.73

* 192,809 members.

ference in wages, however, a direct comparison is impossible. The maternity benefits probably cost a proportionately greater amount because of the large female membership (about 33 per cent) and the consequent large number of births—56 per 1,000 of the

female membership, or 19 per 1,000 members. The cost of funerals may appear low because of the small funeral benefit (only about \$9.25 per case). A comparison between medical benefits and sickness benefits may nevertheless be made. The proportion of medical aid to sickness benefits is M. 17.58 to M. 18.88, or 93.5 per cent. Since the cost of the sick benefits has been determined at 1.908 per cent of the wages, the cost of medical aid would amount to 1.784 per cent of the wages. However, an important correction must be made in this calculation. The German sickness benefit is based upon a 50 per cent scale; we have assumed a two-thirds scale of benefits. Had we assumed a 50 per cent scale, the cost would not be 1.908 per cent, but three-fourths of it, or 1.431 per cent, and in proportion to this the medical benefit would only be 1.338 per cent.

The assumption that in proper proportion to wages medical aid would not cost more in America than in Germany may be easily criticised. It is intended only as a rough approximation. Of course, the experience of thirty years has given Germany an efficient organization which results in a low cost per unit of service. But, on the other hand, the higher basis of American wages permits of a much higher rate of compensation per case within the same proportion of cost to wages. The average cost of simple medical aid per member in Leipzig was about one-half of the combined cost of medical aid, drugs, and hospital care. In actual amounts it was some M. 9

per annum, or about \$2.15. If the computation made above be accepted, the cost of simple medical aid in the United States would be 0.65 per cent of \$600 to \$1,000, or \$4 to \$6.50 per insured. It is quite certain that this would offer a substantial income to the attending physician.⁵

The cost of the health-insurance system as a percentage of wages, as here computed, appears as follows:

	Per cent
Money benefits	1.908
Maternity benefits .....	.072
Funeral benefits .....	.432
Medical aid	1.338
	<hr/> 3.750

About 10 per cent of this amount must be added for administrative expenses, thus bringing the total up to about 4 1-8 per cent of the wages. In all the computations the intention was to overestimate

⁵ The same problem may be approached statistically in a somewhat different manner. For the 12 months ending September, 1913, the physicians of the Leipzig performed the following amount of work:

	For members of funds	For members' dependents	Total
Office calls	1,084,940	492,741	1,577,681
Visits to patients	138,612	285,569	424,181
Operations	100,542	52,670	153,212
Total	<hr/> 1,324,094	<hr/> 830,980	<hr/> 2,154,974

Since the average number of members (exclusive of their

rather than underestimate, with the avowed purpose to allow for all possible margins, and make the result one of a possible maximum rather than one of true probability. Still it seems very probable that the total cost for the entire system will approximate 4 per cent on an average, and in a good many localities or industries will rise even higher. It is doubtful whether anywhere it will be below 3 per cent. The law might reasonably state the limits between 3 and 5 per cent. If a fund should desire to reduce the total contributions below 3 per cent, it might well be required to give evidence satisfactory to an actuary that it does not face the danger of bankruptcy. On

dependents) was \$97,987, the average amount of work per member was as follows:

	For member	For dependents	Total
Office visits	5.22	2.37	7.59
Home visits .....	.67	1.37	2.04
Operations .....	.48	.26	.74
	<u>6.37</u>	<u>4.00</u>	<u>10.37</u>

In view of the large number of "operations" performed evidently even the simplest manipulations were probably included. The medical work thus even in the high development in Leipzig represents some 6 office calls and about 2-3 of a visit per insured person; with the entire family covered, roughly 2 1-2 calls and 1 1-2 visits per insured member must be added. It would seem that with proper organization this amount of medical work could be done for about \$5 or \$6 per capita. It is doubtful whether at present the physician practicing among the poor wageworker can collect such an amount on the average.

the other hand, an increase of the contributions beyond 5 per cent would seem to call for careful investigation as to causes.⁶

The actuarial computation made above may well raise two questions: Is it worth while? Is it feasible? The discussion of these questions may be somewhat beyond the scope of this chapter, but their importance may justify a brief deviation. Perhaps a brief answer to these may serve instead of a summary and conclusion.

Assuming that most wages fall between \$500 and \$1,000 a year, 4 per cent of that will amount to from \$20 to \$40 per annum. The sum is not inconsiderable. For the twenty-odd million wage-workers of the United States, it will represent the staggering amount of perhaps \$600,000,000 per annum. But

⁶ Of course, if the benefits are reduced below the standards outlined here, the cost will correspondingly decrease. Moreover, one important factor has been omitted in the above computation—namely, the saving for not paying the first three days of illness.

For purposes of forming an estimate of the bill introduced in Massachusetts, and identical with the Mills Bill in New York, which eliminated maternity benefits and medical aid for the members of the families, the following computation was submitted by the writer to the Massachusetts legislative committee early in March of 1916:

**'APPROXIMATE COST OF THE MASSACHUSETTS HEALTH INSURANCE
BILL**

I. Sick Benefits

1. Assumed sick-rate, or number of sick-days per member, on the basis of German and English experience (to be on the

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it is not all an additional charge. No one knows how much the American working class pays at present for sickness benefits, medical aid, and for funeral insurance together. We do know, however, that for the last and least important aspect of the entire problem, funeral insurance, over \$200,000,000 annually is paid to industrial insurance companies. In the investigation made some twelve years ago by the United States Bureau of Labor, it was ascertained that the expenses for sickness and death (exclusive of sickness benefits) amounted to \$26.78 per family. If, therefore, \$30 per annum on an average can grant all the benefits which have been outlined in a

safe side, assumption is liberally made)—10 days, or 1.43 weeks.

2. Sick benefit for 1.43 weeks, on the basis of two-thirds of wages, in weeks wages (w. w.)

$$66 \text{ per cent w. w.} \times 1.43 = .954 \text{ w. w.}$$

3. Discount for first three days (Leipzig experience 88,743 cases, total sick days 2,138,000, first three days. $88,743 \times 3 = 266,229$, or 12.5 per cent).

$$.954 \text{ w. w.} \times .125 = .119 \text{ w. w.}$$

$$.835 \text{ w. w.}$$

4. Cost of sick benefits in per cent of annual wages.
 $.835 \text{ w. w.} \div 50 = 1.67 \text{ per cent.}$

II. Funerals.

1. Assumed death rate per 1,000 employees over 16 years of age (basis of U. S. Census).. 16
2. Cost of funerals per 1,000 employees at \$50 per funeral \$800
3. Cost of funerals per insured employees 80c
4. Cost in per cent of wages (\$600 per annum) .133 per cent

previous chapter, the answer seems to be that it is decidedly worth while.

But is this scheme feasible? Does it permit of universal application? If the cost of insurance, as here computed to vary between 3 and 5 per cent, were to be levied in its entirety on the wage-workers, it would produce in most working-men's families a disturbance of their economic equilibrium such as would force them to look at this comprehensive structure of social legislation as a sheer expression of governmental tyranny. A study of the available statistical data has led the writer to the conclusion that the economic evolution of the last twelve years has resulted in a reduction of the real wages in the

III. Medical Benefit

On basis of Leipzig experience:

1. Medical benefit 93.5 per cent of sick (money) benefits.
2. Since basis of sick benefits under Massachusetts bill is 66 2-3 per cent instead of 50 per cent, the equivalent proportion would be

$$\frac{.935 \times .50}{.667} = .70 \text{ per cent.}$$

3. Leipzig system provides medical benefit for entire family, and the Massachusetts bill for employee only. A very liberal assumption is one-half the cost, 35 per cent.
4. If sick benefit 1.67 per cent
then medical benefit $1.67 \times .35 = .585$ per cent.

Total:

Sick Benefit	1.670 per cent
Funeral .....	.133 "
Medical .....	.585 "
	<hr/> 2.388 per cent.

United States by some 10 or 15 per cent.' That was a slow process and did not result in anything more threatening than grumbling. The opposition to a definite slash of several per cent at one stroke would be such that no political party anxious to remain in power would be likely to stand ready to face the music. Thus, entirely irrespective of any claims to justice in apportionment, the distribution of the cost between the employer and employee, with a substantial contribution from the state, is the only way in which this large program may be realized.

On an assumption of an expense rate of 15 per cent gross (which is very high) the gross average cost will be

$$2.388 \div .85 = 2.80 \text{ per cent.}$$

Distributed as follows:

Employee	40	per cent	or	1.12	per cent
Employer	40	"	or	1.12	"
State	20	"	or	.56	"
				<hr/>	
				2.80 per cent.	

IV. *Fluctuations*

According to sick rate.

Sick rate varies, according to occupation, between 5 to 15 days (only in a few extremely unhealthy trades does it rise above 15).

	Minimum 5 days' sick rate <i>p. c. of wages</i>	Maximum 15 days' sick rate <i>p. c. of wages</i>
Cost of sick benefit .....	.835	2.505
Funeral .....	.133	.133
Medical .....	.293	.878
<hr/>		<hr/>
Administration .....	.422	.422
<hr/>		<hr/>
1.683		3.938

' See "Recent Trend of Real Wages," *American Economic Review*, Dec., 1914, p. 793.

APPENDIX I

CONSTITUTIONALITY OF HEALTH INSURANCE

BY JOSEPH P. CHAMBERLAIN

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A HEALTH insurance law should provide medical benefit for employees and their families, including maternity benefit, cash payment during a given period to employees unable to work on account of sickness, and funeral benefits. The necessary funds should be raised by contributions from employers, employees, and the state. Many questions of the constitutionality of such legislation might arise in connection with particular provisions of state constitutions; but it is not intended here to discuss any other limitations upon the legislature than those contained in the Fourteenth Amendment to the Constitution of the United States and the similar provisions found in nearly all the state constitutions: "nor shall any state deprive any person of life, liberty, or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws." The first prohibition brings before the Supreme Court any legislation affecting individual liberty and property; the second prohibits arbitrary and unreasonable action in regard to individuals or classes of individuals, so that a compulsory health-insurance law must be submitted to judicial scrutiny.

The present necessity for brevity prevents any attempt to meet objections to details of a possible law, so that all which will be attempted is to state broadly the principles which must be kept in mind by drafters of the health-insurance legislation which seems inevitable.

PRESUMPTION OF CONSTITUTIONALITY

It is important to remember that the courts should never declare an act of the legislature unconstitutional unless its unconstitutionality is clearly proved. The burden of proof, and it must be conclusive, is upon those who deny the constitutionality of an act, while those who support it need only to refute objections by raising a reasonable doubt in the minds of the judges that the legislature has exceeded its powers.

Judge Cooley, a writer of great authority, says in his work on *Constitutional Limitations*, p. 254:

"The constitutionality of a law, then, is to be presumed, because the legislature, which was first required to pass upon the question, acting, as they must be deemed to have acted, with integrity, and with a just desire to keep within the restrictions laid by the constitution upon their action, have adjudged that it is so."

He quotes from two early decisions of the U. S. Supreme Court to support his contention, p. 253:

"The opposition between the constitution and the law should be such that the judge feels a clear and strong conviction of their incompatibility with each other."—*Fletcher v. Peck*, 6 Cranch 87, 128.

"But if I could rest my opinion in favor of the constitutionality of the law on which the question arises, on no other ground than this doubt so felt and acknowledged, that alone would, in my estimation, be a satisfactory vindication of it.

It is but a decent respect due to the wisdom, the integrity, and the patriotism of the legislative body by which any law is passed, to presume in favor of its validity, until its violation of the constitution is proved beyond all reasonable doubt."—*Ogden v. Saunders*, 12 Wheat. 213.

The Supreme Court has not modified its opinion. It says in *Atkin v. Kansas*, 191 U. S. 207, p. 223:

"We are reminded by counsel that it is the solemn duty of the courts in cases before them to guard the constitutional rights of the citizen against merely arbitrary power. That is unquestionably true. But it is equally true—indeed, the public interests imperatively demand—that legislative enactments should be recognized and enforced by the courts as embodying the will of the people, unless they are plainly and palpably, beyond all question, in violation of the fundamental law of the Constitution."

The court of New York stated the same point although in a little different way:

"The people, in framing the constitution, committed to the legislature the whole lawmaking power of the state which they did not expressly or impliedly withhold. Plenary power in the legislature for all purposes of civil government is the rule. A prohibition to exercise a particular power is an exception. In inquiring, therefore, whether a given statute is constitutional, it is for those who question its validity to show that it is forbidden."—*People v. Draper*, 15 N. Y. 532, 543.

The serious results which might flow from any other rule are very clearly expressed in the same case:

"The wisdom of the conservative maxims of the courts is further exhibited by the consideration that the legislatures are chosen at frequently occurring elections and for short terms. Hence, if they err in expressing the wants of the people, or exceed their powers, the error or excess may be quietly and quickly corrected by the people themselves, through subsequently elected representatives. But if this court wanders from its judicial orbit, and in its progress collides with a co-ordinate power, when moving in its legitimate sphere, who shall restore the system of harmony and regulate its dynamical

forces? Such collision must terminate either in judicial revolution or new constitutional compacts" (p. 549).

See also *Holst v. Roe*, 39 Ohio State 340.

In his powerful essay on "Constitutional Law," Professor Thayer shows very clearly the proper limit of the power of the court. Its duty is not to decide whether or not the law is, in its own best judgment, in conformity with the constitution, but is to determine whether as reasonable men a legislature could have believed that they were within their power in passing it. "The ultimate question is not what is the true meaning of the constitution, but whether (the law) is sustainable or not." (Thayer, *Legal Essays*, p. 30.)

POWER TO ENACT LAWS TO PROMOTE HEALTH

The first prohibition of the Fourteenth Amendment does not deprive the legislature of power to pass laws under what is indefinitely known as the police power, to promote or protect health. In the *Boston Beer Company v. Massachusetts*, 97 U. S. 25, 33, the court says:

"Whatever differences of opinion may exist as to the extent and boundaries of the police power, and however difficult it may be to render a satisfactory definition of it, there seems to be no doubt that it does extend to the protection of the lives, health, and property of the citizens, and to the preservation of good order and the public morals. . . . They belong emphatically to that class of objects which demand the application of the maxim, *Salus populi suprema lex*; and they are to be attained and provided for by such appropriate means as the legislative discretion may devise."

More recently in *Jacobson v. Massachusetts*, 197 U. S. 11, 25, the point is also made:

"The police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety."

Judge Holmes stated the case more broadly in the *Noble State Bank v. Haskell*, 219 U. S. 104, 111:

"It may be said in a general way that the police power extends to all the great public needs. *Camfield v. United States*, 167 U. S. 518. It may be put forth in aid of what is sanctioned by usage, or held by the prevailing morality or strong and preponderant opinion to be greatly and immediately necessary to the public welfare."

The reason, the necessity, for leaving the legislatures free to deal with health is laid down by the Supreme Court of the United States in *Holden v. Hardy*, 169 U. S. 366, 397, quoting and approving the words of the Supreme Court of Colorado:

"The whole is no greater than the sum of all the parts, and when the individual health, safety, and welfare are sacrificed or neglected the state must suffer."

The Court of Appeals of New York states it thus in *People v. Havnor*, 149 N. Y. 195, 208:

"It is to the interest of the state to have strong, robust, healthy citizens, capable of self-support, of bearing arms, and of adding to the resources of the country. . . . The physical welfare of the citizen is a subject of such primary importance to the state, and has such a direct relation to the general good, as to make laws tending to promote that object proper under the police power, and hence valid under the Constitution, which 'presupposes its existence and is to be construed with reference to that fact.'"

The problem before the court in reconciling a health-insurance law with the Fourteenth Amendment will be whether health insurance is designed to improve the public health and whether the particular act in question may be supported as reasonable. The considerations

which control it are laid down in *McLean v. Arkansas*, 211 U. S. 539, 547:

"It is also true that the police power of the state is not unlimited and is subject to judicial review and, when exerted in an arbitrary or oppressive manner, such laws may be annulled as violative of rights protected by the Constitution. While the courts can set aside legislative enactments upon this ground, the principles upon which such interference is warranted are as well settled as is the right of judicial interference itself. The legislature being familiar with local conditions is primarily the judge of the necessity of such enactments. The mere fact that a court may differ with the legislature in its views of public policy, or that judges may hold views inconsistent with the propriety of the legislation in question, affords no ground for judicial interference unless the act in question is unmistakably and palpably in excess of legislative power."

Clearly, the limitations upon the power of the court make it certain that it will but rarely declare unconstitutional acts which affect health. There is, it is believed, no case in which a statute really regulating health has been held unconstitutional by the Supreme Court. In one celebrated case the court reviewed the operation of a statute which had been upheld in a state as a health law and declared that it was not a health law and so reversed the state court. (*Lochner v. N. Y.*, 198 U. S. 45; Freund on *Police Power*, p. 124.)

In determining whether or not a law is a health law and therefore whether it is reasonable, the courts will consider the facts. In *Muller v. Oregon*, 208 U. S. 412, the court considered a brief containing extracts from the laws of many American states and foreign countries and extracts from economic reports both in this country and in Europe. In *Bosley v. McLaughlin*, 236 U. S. 385, the court quoted from a bulletin of the United States Bureau of Education. In upholding the Wash-

ington Compulsory Compensation Law the state court depended in part upon the opinions of "modern statesmen, jurists, and economic writers" and the fact that the principle had been enacted into law in Europe. (*State v. Clausen*, 117 Pacific 1101.) The Court of Appeals of New York depended chiefly upon the facts gathered by a legislative investigating commission to reverse its former opinion that a law limiting night work for women was unconstitutional. (*People v. Charles Schweinler Press*, 214 N. Y. 399.) The evidence was admitted to show that the legislature had a sufficiently reasonable basis for taking the action which it did to permit the court to uphold the legislative decision. (See also *Jacobson v. Massachusetts*, *supra*; *Hennington v. Georgia*, 163 U. S. 299; *People v. Havnor*, *supra*; *Holden v. Hardy*, *supra*; *People v. Klinck Packing Co.*, 214 N. Y. 121.) If the legislature is convinced that steps should be taken to care for the health of employees and believes that the insurance method is the best way to do it, the cases hold that the Supreme Court will not declare the statute unconstitutional if a reasonable economic argument in its favor can be made. In that argument it may be urged that health insurance is a long established and successful method of conserving health in Europe.

A health law need not affect directly the whole population in order that its purpose be public. It is sufficient if the health of the class affected be a legitimate public interest, and many statutes and decisions testify to the fact that the health of employees, or even of single classes of them, is a public interest [see cases cited above]. Section 19 of Article I of the New York Con-

stitution permits the insurance of "employees" against "injury." The One Day Rest in Seven Law recently passed in New York, which prohibits all employers in factories or mercantile establishments from working their employees more than six days in seven, was upheld in the case of *The People v. Klinck Packing Co.* as "a valid exercise of the police power of the state for the promotion and protection of the public health and welfare." A New York law prohibiting barbers from working on Sundays was sustained for the same reason; the health of a single class of working people, barbers, was held a public interest. (*People v. Havnor*, supra.) In *Booth v. Indiana*, 287 U. S. 391, a statute which provided for wash-houses in coal mines when requested by twenty or more men was objected to as applying only to a particular class and as not therefore in the interest of the public health. The United States Supreme Court held that its previous decisions disposed of this point in favor of the constitutionality of the law "and further comment is unnecessary." The decision in *Lochner v. New York*, 198 U. S. 45, declaring unconstitutional the bakers' eight-hour law is not an authority against this view. The court there says: "The act is not, within any fair meaning of the term, a health law." It seems, therefore, clear that the legislature may properly limit compulsory health insurance to all manual workmen and for all employees up to a certain fixed limit of earnings.

Mr. Freund, the most frequently quoted text writer on the subject of the police power, sums up his opinion on the constitutionality of compulsory health insurance in § 437 of his book on *Police Power*:

"In a large sense, the community is certainly interested in averting sudden and unexpected losses as well as the destitution

following from sickness and disease, and the distribution of these losses over large numbers through insurance is a legitimate end of governmental policy. There is no warrant for denying the state the power to adopt compulsory measures for the purpose; whether such measures should be adopted where public sentiment is averse to such policy, and the same objects are adequately attained by voluntary co-operation, is a question of policy and not of law. It may, however, be safely asserted that compulsory insurance requires that either the state itself becomes the insurer, or that it exercise an efficient control over private or semi-public associations which the individual is compelled to join; for this alone eliminates from the problem the difficulty that the state would force the individual to enter into contract relations with other private parties without substantially guaranteeing performance to the individual who is required to part with his money."

CLASSIFICATION

A health-insurance law will bring under compulsory insurance all employees engaged in manual labor and all others earning less than a certain salary. Therefore, the question will arise whether the legislature may fairly put them in a class for the purpose of the insurance as against other persons both to require them to pay contributions and to grant them the benefits. If employers also are singled out as a class on whom part of the burden is to be placed, another difficulty of classification arises. The courts are very liberal in construing the power of the legislature to classify the objects of legislation. Unless this classification is clearly arbitrary and unfair or unless it has no connection with the object to be attained, the courts will sustain it and will not require that it should be a classification which they themselves would have made. In *Lindsley v. Natural Carbonic Gas Co.*, 220 U. S. 61, the court, on page 78, lays down rules which have been since frequently quoted to determine what is permissible classification:

"The rules by which this contention must be tested, as is shown by repeated decisions of this court, are these: 1. The equal protection clause of the 14th amendment does not take from the state the power to classify in the adoption of police laws, but admits of the exercise of a wide scope of discretion in that regard, and voids what is done only when it is without any reasonable basis, and therefore is purely arbitrary. 2. A classification having some reasonable basis does not offend against that clause merely because it is not made with mathematical nicety, or because in practice it results in some inequality. 3. *When the classification in such a law is called in question, if any state of facts reasonably can be conceived that would sustain it, the existence of that state of facts at the time the law was enacted must be assumed.* 4. One who assails the classification in such a law must carry the burden of showing that it does not rest upon any reasonable basis, but is essentially arbitrary."

Very recently, in passing upon the classification made in the Ohio voluntary compensation law which distinguished between employers of five men or more and those of under five men, the court said:

"This court has many times affirmed the general proposition that it is not the purpose of the 14th amendment in the equal protection clause to take from the states the right and power to classify the subjects of legislation. It is only when such attempted classification is arbitrary and unreasonable that the court can declare it beyond the legislative authority. *Lindsley v. Natural Carbonic Gas Co.*, 220 U. S. 61, 78. That a law may work hardship and inequality is not enough; many valid laws, from the generality of their application, necessarily do that and the legislature must be allowed a wide field of choice in determining the subject-matter of its laws, what shall come within them and what shall be excluded." (*Jeffrey Mfg. Co. v. Blagg*, 235 U. S. 571, 576.)

[*Patsone v. Pennsylvania*, 232 U. S. 138, 144.

Missouri, K. & T. Ry. Co. v. Cade, 233 U. S. 642, 650.

International Harvester Co. v. Missouri, 234 U. S. 199, 215.

Miller v. Wilson, 236 U. S. 373, 384.

Price v. Ill., 238 U. S. 446, 453.]

If, therefore, the classification proposed is broadly reasonable, the law will not be invalidated by the fact that certain employees or certain employers will not get

a benefit equal to that received by others, or that their contributions will not be nicely adjusted to the exact relation of the sickness rate of their trade or shop with sickness rates with other trades or shops. The grounds for limiting compulsory insurance to certain employees and for singling out employers as contributors have been explained in the preceding chapters. Can it be said that under the liberal rule laid down by the court they would not justify the broad classification proposed?

ASSESSMENT OF CONTRIBUTIONS

It is no new thing for the legislature to authorize the taking of property by assessment for purposes calculated to promote the public health or public interest—for instance, the contributions for sewers. These assessments are laid under the police rather than the taxing power, and, in any case, are not subject to the general constitutional limitations on the taxing power; nor is the money raised subject to limitations on the expenditure of money for general state or local purposes. (Cooley on *Taxation*, 3rd Edition, Chs. XIX, XXI, especially on p. 1300, and p. 1168, *Taxation by Assessment*, Page & Jones, § 5, § 78 ss, *Paulsen v. Portland*, 149 U. S. 30.)

Under the Drainage Act in New York, persons owning property may be compelled to pay for its drainage if commissioners appointed by the county court decide that drainage would benefit the public health. (*Matter of Ryers*, 72 N. Y. 1; *Matter of Lent*, 47 A. D. 349; *Davidson v. New Orleans*, 96 U. S. 97.) A statute enacted in several Western states requires all land holders within a district to pay assessments to provide and maintain a supply of water for irrigation. Even though the person

assessed did not need the water and objected to the formation of the district he must assume his share of the burden. (*Fallbrook Irrigation District v. Bradley*, 164 U. S. 112; see also *Hagar v. Reclamation District*, 111 U. S. 701.)

The legislature has authorized taxation of particular occupations or property to create funds for special purposes, and the legislation has been held to be an exercise of the police rather than of the taxing power. Insurance agents have been taxed to raise money for the support of firemen's benevolent associations. (See *Firemen's Benevolent Association v. Lounsbury*, 21 Ill. 511; *Exempt Firemen's Benevolent Fund v. Roome*, 98 N. Y. 313.)

Owners of dogs have been taxed to create a fund out of which damages are paid to the owners of sheep killed by dogs. (*McGlone v. Womack*, 129 Ky. 274; *Holst v. Roe*, 39 Ohio State 340; *Van Horn v. People*, 46 Mich. 183.)

Banks have been taxed on their deposits to create a fund out of which depositors in banks becoming insolvent are to be repaid. (*Noble State Bank v. Haskell*, 219 U. S. 104; *People v. Walker*, 17 N. Y. 502.)

A system of land registration known as the Torrens Act adopted in many states provides for a tax on all property registered to form a fund from which claims against registered property are paid. (§ 426 Real Property Law of New York, as amended Ch. 547, L. 1916.)

The United States formerly collected from the masters or owners of vessels a monthly tax of 40 cents for each sailor to support the marine hospital service. The master or owner was empowered to retain this sum from

the wages of the sailor. (§ 4585 Revised Statutes, abolished by Act of June 26, 1884; Freund, *Police Power*, § 484.)

The legislature furthermore has often taken the property of employer and employee for the benefit of the health of the employee. The right to freely contract for labor is a property right both of the employer and of the employee, and the right to a "proper and free use of his property" is another property right of every individual. (*Ritchie & Co. v. Wayman*, 244 Ill. 509, p. 518, and *In re Jacobs*, 98 N. Y. 98, p. 105.) An employee may, as was said by the United States Supreme Court in *Lochner v. New York*, 198 U. S. 45, desire to earn extra money by working more than eight hours, and a statute limiting hours of work would prevent his earning it. Limitations upon either of these rights, though the taking of property under the fourteenth amendment, have, when not unreasonable, been held constitutional as health laws. A statute limiting the workday of miners to eight hours was upheld in *Holden v. Hardy*, 169 U. S. 366. That the legislature may prohibit Sunday work for barbers was affirmed in *Petit v. Minnesota*, 177 U. S. 164; *People v. Havnor*, 149 N. Y. 145, or railroad men in *Hennington v. Georgia*, 163 U. S. 299. Women have the same right to labor as men, yet their workday may be reduced to ten hours in certain employments, *Muller v. Oregon*, 208 U. S. 412, or even to eight, *Miller v. Wilson*, 236 U. S. 373, and they may be forbidden from doing night work, *People v. Schweinler Press*, 214 N. Y. 399. All employees in factories or mercantile establishments can be compelled to quit work one day in seven, *People v. Klinck Packing Co.*, 214 N. Y. 121.

The question as to use of property of the employer is fully brought out in *People v. Havnor*, in which a proprietor of a barber shop urged that a statute which prevented barbers from working on Sundays deprived him of his property by "preventing the free use of his premises, tools and labor, and thus rendering them less productive." The court said: "Whatever prevents him from freely using his lands or chattels is a deprivation of his property," (p. 199), but held that the taking was constitutional, as it was in the interest of the public health. The right to property is protected by the same words of the constitution as the right to liberty. It has been frequently held that the right to liberty included the freedom to make contracts to buy and sell labor; but this liberty may be in part taken away from employer and from employee by legislation regulating the hours of labor. [See cases cited above.]

If it is permissible, as in the one day rest in seven laws, to deprive the employee of the right to work and, therefore, to earn wages during one day in seven, if it is proper to prevent his working more than eight hours or ten hours, and, therefore, deprive him of a certain portion of the income which he might otherwise have received, and if these property rights can be taken from him only on the score of the benefit to his health, it certainly cannot be argued that the state may not compel him to contribute a reasonable share of his earnings to provide for his health. If an employer must be content to lose his right to contract with an employee for work on one day in the week, if his right to use his property to its best advantage may be curtailed by the requirement that he allow each one of his employees

one day off in seven, or even that he, as in some Sunday laws, cease operations altogether, and if his property right to freely contract with his employees and his right to use his plant are affected by statutes limiting the number of hours of labor, and all for the benefit of the health of his employees, can it be maintained that in principle the state cannot require him to contribute directly toward a provision for the health of his employees?

The fourteenth amendment will stand in the way of arbitrary and unreasonable assessment. (*Davidson v. New Orleans*, supra.) There must be either a reasonable expectation of benefit to the contributors or it must appear that the legislature might reasonably require them to make some provision for the protection of employees. There must be a relation between the subject of the assessment and the object for which the money is to be spent, similar to the relation between the ownership of dogs and the killing of sheep; the business of an insurance agent and firemen's benevolent funds; the ownership of marsh lands and the necessity for drainage; the operation of a factory and the need of the operators for one day's rest in seven. This is a question of fact. But the action of the court, in allowing great weight to the proof of actual conditions in passing upon labor legislation, will make the task of the proponents of health-insurance laws much easier. ("Hours of Labor and Realism in Constitutional Law," by Felix Frankfurter, *Harvard Law Review*, Vol. XXIX, No. 4.)

NEW YORK CONSTITUTION

In New York the question of the constitutionality of health insurance seems settled by Section 19 of Article I of the constitution, which clearly extends the power of the legislature beyond making provision for trade accidents and occupational disease, and the case of *Jensen v. Southern Pacific Company*, 215 N. Y. 514, holding that a compulsory act to provide insurance against industrial accidents passed under that section is not in conflict with the Fourteenth Amendment of the United States Constitution.

"Workmen's Compensation. § 19. Nothing contained in this Constitution shall be construed to limit the power of the Legislature to enact laws for the protection of the lives, health, or safety of employees; or for the payment, either by employers, or by employers and employees, or otherwise, either directly or through a state or other system of insurance or otherwise, of compensation for injuries to employees or for death of employees resulting from such injuries without regard to fault as a cause thereof."

Evidently "injuries to employees" does not refer to accidents alone or to industrial injuries alone. The words "by accident" used in workmen's compensation laws to limit the word "injuries" are significantly omitted. The Constitution of California uses the word "injury" without this limitation (Art. XX, § 21) and in that state the statute formerly reading "injuries by accident" has been changed by omitting the words "by accident" in order to include disease. (Chap. 607, Acts of 1915.) In Massachusetts, where the word "injury" alone was used and there were no complications to create difficulty, the word has been held to include disease.

(*Johnson v. London Guarantee & Accident Co.*, 104 N. E. 735; *Hurle v. American Mutual Accident Co.*, 217 Mass. 223.)

The words "arising out of and in the course of employment" used to limit workmen's compensation acts to purely industrial injuries were deliberately omitted from Section 19, as is shown by the fact that they were contained in substitute amendments rejected by the legislature. Article XX, § 21 of the California Constitution also contained these limiting words and this constitutional provision was in effect at the time of the adoption of the New York amendment. No law or bill creating a system of workmen's compensation for industrial accident and occupational disease has ever included cash contributions by employees or the state; but the various systems of health and other forms of social insurance in existence in Europe at the time Section 19 was adopted were based on the principle of joint contributions authorized by the amendment. The provision in the California Constitution, restricted to "injuries in the course of . . . employment," authorizes the legislature to put a burden upon "employers" alone.

It would be difficult to find words more appropriate than those used in Section 19 to confer on the legislature that full discretion in dealing with all injuries to employees which was the obvious purpose of the amendment. A constitutional amendment, drawn for the express purpose of vesting discretion in the legislature to deal as it thought proper with the problem of providing for employees' injuries due to sickness, would practically repeat the language of Section 19.

So far as the New York Constitution is concerned,

then, it may be argued that there is nothing to prevent a system of health insurance wholly paid for by the employers or wholly paid for by the state or generally by employer, employee, and the state. The Fourteenth Amendment of the Federal Constitution, however, gives supervisory power to the courts, state and federal, to prevent the operation of state laws which unreasonably burden any one class or individual. Probably a law putting the whole burden of sickness of employees on employers would be held unreasonable and, therefore, unconstitutional, but can it be denied that a contribution by employers to a health-insurance fund would be justified by the present information of the share of industry in causing and in accelerating disease and by the consideration of the advantage gained by an employer from improved health of his workmen, especially if the act limited correspondingly his liability in damage suits?

The Jensen case, furthermore, clearly adopts the view that the compensation law there approved was an insurance law passed under the "police power" of the state; that it was not a mere improvement on the method of settling and paying legal claims and a mere extension of the liability of the employer. Both employer and employee gave up rights. From the employer is taken his right to limit recovery to cases of fault; from the employee his right to full payment as assessed by a jury for injuries caused by fault, "his contribution to an insurance scheme designed for his benefit." Could a health-insurance law be better described than by these sentences in that decision:

"Surely it is competent for the state in the promotion of the general welfare to require both employer and employee to yield something toward the establishment of a principle and plan

of compensation for their mutual protection and advantage. Any plan devised by the wit of man may in exceptional cases work unjustly, but the act is to be judged by its general plan and scope and the general good to be promoted by it. Fortunately the courts have not attempted to define the limits of the police power. Its elasticity makes progress possible under a written constitution guaranteeing individual rights" (p. 528).

The court, in the Jensen case, relies on the Oklahoma Bank Tax case, *Noble State Bank v. Haskell*, as an authority in its argument that the law is not forbidden by the Fourteenth Amendment. In that case Judge Holmes says, in the same vein:

"It would seem that there may be other cases besides the everyday one of taxation, in which the share of each party in the benefit of a scheme of mutual protection is sufficient compensation for the correlative burden that it is compelled to assume" (p. 111).

There is no logical difference between sickness caused by negligence and accident caused by negligence. With the removal of the common law defenses and the advance in medical and sanitary knowledge a wide field is opened for employers' liability. Increasingly the labor law puts the "health" of employees on the same plane as their "safety." "Sanitary" is included as one of the requirements of a safe working place. While these provisions may not in themselves constitute a basis for suits for common law damages, they show a growing opinion that loss through sickness is on the same plane as loss through accident, an opinion which will form the basis for an extended liability through a growth of the law by court decision or by legislation. (New York Labor Law § 51-a, subdiv 2, § 20-b; Burdick on *Torts*, third edition, § 183; *Collins v. Harrison* 64 L. R. A.

156.) The justification for requiring contributions of the employees, aside from the authority of the Jensen case, could clearly be based on the benefit which they get and on the fact that much sickness arises from their habits of living and personal carelessness. As to the state's contribution, it cannot be doubted that the health of the people is a public purpose and that either public or private institutions supervised by the state, which may clearly be said to improve the public health, may receive state aid. (See Freund on *Police Power*, §§ 433-437, inclusive.)

APPENDIX II

ORGANIZATION OF MEDICAL AID

*Preliminary Report to the Social Insurance Committee
of the American Association for Labor Legislation*

BY ALEXANDER LAMBERT, M.D.

IN considering any scheme of medical relief under the Sickness Insurance Act one must consider it from three points of view: the medical point of view, the patient's point of view, and the view of the insurance-carriers.

In beginning the consideration of the medical point of view, it is necessary to consider certain medical customs and habits of thought. The medical service is always an individual one and the state requires it to be individual. Medical public opinion demands that the physician shall give an adequate and just service to his patient and that the physician shall not permit himself to be placed in positions where he gives careless, incompetent service to the injury of those under his care. Any physician neglecting this standard loses caste. He is condemned by his colleagues, and the position or system in which such service is likely to occur is held in contempt by the profession and has been classified under the opprobrious name of "contract practice." All medical service is really a contract, and many physicians under salaries, such as with insurance companies or rail-

roads, are not condemned, nor do they lose caste by accepting such contracts. But any contract which carries with it an unreasonable amount of work by the doctor, which in turn forces neglectful, hurried service to the patients, is always condemned. These situations are usually found in certain lumbering and mining camps and under other corporations, and in the familiar lodge practice in large cities.

Lodge practice and other condemned forms of contract practice are all under the capitation plan of remuneration, and the capitation idea of service under sickness insurance has necessarily these inherent faults which cannot be eradicated and can only be controlled to a limited extent if they can be controlled at all. By this form of capitation is meant the per patient per year form of payment to the doctor. Another form of capitation which is used abroad is frequently used in a compromise with the free choice system of the doctor by the patient; that is, a sickness society has a certain amount of funds that it can pay for medical services to the doctors. This lump sum it gives to some association of doctors, and the physicians charge up each visit and each act of service rendered to each patient as so many points of work done against the medical society. At the end of the year, each physician hands in his account to the medical society and the total number of points are divided into the total amount of funds, and the remuneration paid to the physicians pro rata. The two faults in this country for this method are that there is no society or association of physicians which is sufficiently universal in its membership to justify such a procedure, for many men who would work among the

working classes do not belong to the medical societies, and if any control was attempted through the present societies, there would be many doctors working among the insured who would be beyond such control; and, furthermore, in times of great amount of sickness, the more work that is done the less is each point of service worth, and after a certain amount of services has been given by the physicians the more work they do, the less money do they receive in ratio to work done. If the total amount paid by the societies remained the same, and if twice as much work were done by the doctors in an epidemic as in an average year, each point would be worth half as much and the remuneration would be the same under great stress of work as under an average year. This is not just remuneration and would soon bring a resentment on the part of physicians because of undervaluation of their work and the injustice in it, and there soon would develop a situation similar to the other form of capitation of overcrowded work and the underpaid men.

There is, in some parts of Germany, the regularly paid physician under definite salary from the society. This might or might not work out well, because it would be a similar form of contract to that of the railroad surgeons, but it would be very liable in sickness insurance to be abused, and soon the inherent faults, as in capitation, would develop. Moreover, any sickness-insurance society could only hire a certain number of physicians, and unless they arbitrarily refused free choice of physicians to their members and divided them in equal numbers among their salaried physicians, the natural difference in personality of the physicians would

immediately cause some of their practices to be overcrowded while others were neglected, and again the inherent faults under capitation develop.

One comes to the other form of medical service—that of visitation, i.e., a stated fee per visit per patient, or with a fee graded according to character of services, with free choice of the physician by the insured, either with an unlimited number of patients or with a limited number of patients under a panel system, by which a definite number of patients can be apportioned to any one doctor and under which all patients must be apportioned to some doctor,—this with the consent of the physicians and patients; or, absolute free choice of the physician by the patient, with no panel and no control by the Commission of the physician through his position on the panel; or free choice of the physician by the patient, with control of the physicians through a series of committees.

It has been generally claimed that free choice of physicians and this visitation method of so much per patient per visit always increases the number of visits and the expense of medical care to the insuring societies. These claims, however, were not substantiated in an investigation of the subject in Manchester, England. There is no question that from the medical point of view the visitation system is the most just. There is no question from the patients' point of view that they obtain by this means the best service. There is less danger of neglectful and overcrowded services being rendered to them; it eliminates the inherent faults of the capitation system but increases the expense over capitation because it gives a fair return which capitation does

not do. It seems to increase the opportunity for malingering and simulation, which, unless controlled, become the bane and ruin of any social-insurance system.

The ethics of any profession are but the moral customs of the general community modified to suit peculiar services which that given profession performs, and the ethics of the average member of any profession will not rise any higher than the average of the community in which he lives. In any community, therefore, there will be dishonest physicians whose acts must be controlled that they may render an honest return to the patients and to the insurance-carriers. Therefore, this human factor necessitates a scheme by which this control can be most economically and efficiently exerted. The German system of committees composed of workingmen and physicians seems to meet this situation best. For example, the Leipzig sickness fund has a representative Medical Committee of the Society doctors, a Conciliation Committee, and an Arbitration Committee. This Medical Committee is composed of twelve members chosen every two years by the doctors in the service of the Society. The duties of the Committee relate primarily to the constant supervision and the control of the work of the Society doctors, also to calculating and dividing the remuneration of the doctors and to the maintenance of their rights and interests. They scrutinize the charges that the doctors make; they scrutinize the prescriptions of the doctors for other medical or surgical requirements; they scrutinize the number of persons certified by each doctor who are unable to work, and the length of time of the inability according to statistics prepared by the Society; they determine where there has been

improper excess of the normal average. In case of serious default, as regards certifying patients as unable to work, the Committee deducts from the remuneration of the doctor, for the benefit of the Society, the excess charges incurred in consequence of the default in payment of benefit. The Committee communicates semi-annually to all the Society doctors the result of the statistical preparations on which they have based their work.

This physicians' committee can discipline the doctors when it is found they have been seriously at fault by taking one of the following actions, in addition to making deductions from the doctor's remuneration. They can give him advice or written warning, or, after two unheeded warnings, temporary suspension of from one to twelve months from attendance on society patients. The doctor in default, however, must be heard before a written warning or suspension is invoked. If the doctor has been twice temporarily excluded from the Society practice, without result, if the Society does not use its right to give the doctor a notice to terminate his contract, the Committee may make request to the Arbitration Committee that the doctor be permanently excluded from Society practice. Complaints made by the patient or by the Society in regard to the practice of a doctor are brought before this Medical Committee for its opinion, and the opinion given on the case is communicated to the doctor by the Committee. Circulars and directions which the Society proposes to issue to the doctors are first submitted to the Committee for its opinion; complaints by a doctor against the Society have first to be communicated to the Committee, which has to give an opinion to the doctor on the complaint. This opinion

shall be communicated to the Society. Complaints by doctors in regard to members of the Society are to be communicated by the Committee only if the managing committee of the Society does not give satisfaction to the doctor in regard to the complaints.

It is thus seen that this Committee stands between the general mass of doctors doing work among the insured and the insuring societies. Although the Leipzig Medical Committee of twelve seems to be too large for the best results, any medical committee is able from its expert point of view to understand the viewpoint of the medical profession, which is peculiar to it in matters of ethics and standards, and it can more readily deal out justice because of this expert knowledge. In this country, however, it has heretofore been difficult to obtain discipline of the members of the profession by committees of the profession. Any development toward this end, in New York State in particular, has been further discouraged by several cases in the courts in which medical societies have endeavored to discipline, by expulsion, members guilty of what was believed to be wrong-doing. The courts have almost invariably forced the societies to reinstate the objectionable members and have further delivered to the societies a severe scolding because some minute legal technicalities had not been complied with. The profession has felt that the intricacies of the law have blocked the development of medical control by the profession itself, and the regulation of the profession by the profession in New York State has not developed to the extent that it should have done. Whether or not, under a sickness-insurance law, adequate control of the medical profession by a

medical committee would be possible, cannot be foretold. With this responsibility, however, thrown upon their shoulders and with adequate rules for protection, through such committees, the medical profession should be able to bring about the desired results. If, however, this is not possible, then the medical profession must face the issue of whether or not it will be forced to accept a lay control or a combination of control by laymen and physicians.

A special Conciliation Committee should be appointed for deliberation on questions which appear to require consultation between any society and its doctors, and for the friendly consideration of all kinds of differences. In the Leipzig Society, such a committee is further described as consisting of the chairman of the managing committee of the Sickness Society and of the representative Medical Committees. Such a committee, however, should be a small committee of but, probably, three members, that its efficiency and activity should be at a maximum, and it should be composed of a workman and an employer and a physician, and should be subject to the call of any one of its members.

The Arbitration Committee should be composed of workmen, employers, and physicians, presided over by a member of the Commission, and one member of the committee should be a lawyer. It should be the final committee of appeal from the Medical Committee and the Conciliation Committee, and should be the final committee for discipline of physicians regarding their expulsion and should hear all appeals made from the decision of the Medical or Conciliation Committee. All appeals and disputes between physicians and the insuring so-

cieties or between physicians and any of the insured should also go through it to the Commission.

These committees should not serve without pay. The custom of most corporations in this country of paying a gold piece to their directors at each meeting should be followed in these committee meetings to the extent of giving some definite stipend for attendance at the meeting. Work of this character is arduous, and positions on the committees should be honorable positions and recompense should be given for the work done.

In all sickness insurance there is one mooted question that constantly arises, and that is, Who shall decide any dispute between a physician and an insured member as to whether or not this patient should go back to work and his benefits cease? There is always trouble if this work is left to the physician alone. Patients will demand leniency, will go to the doctors who are lenient, and physicians, unless of rugged character, will be afraid of losing their patients and injuring their income unless they are lenient, and thus the expense of the insurance-carriers will be enormously increased by a continuance on the sick list of patients who should be at work. If, whenever this mooted point arises, the decision could be referred to some impersonal committee or to some regularly constituted, salaried medical referee, it would enormously improve the working of the insurance act. There will probably be required a medical inspection department under a medical referee or referees to control malingering and valetudinarianism.

There is no intention at this time of going into the details of the regulations necessary for the smooth-running of a sickness-insurance scheme. That must be

left as a matter between the various societies and the physicians on the panel; it must be worked out under the Commission and will undoubtedly vary in different sections of the state. It is doubtful if the remuneration to the physicians per patient per visit will vary much in different parts of the state because the sickness insurance is limited to persons of definitely limited wages. The compensation law now demands that medical services shall be paid subject to regulation by the commission and shall be limited to such charges as prevail in the community for similar treatment of injured persons of a like standard of living, but does not limit the wages of those employed who are subject to the Act.

From the patients' point of view, efficient medical service is necessary. Any general sickness-insurance law among the poor will develop an increase of medical service and demands. Some form of sickness or injury has been the calamity through which the poverty of the poor has been changed to destitution in the majority of those applying to charity for aid, so that often all that has separated poverty from destitution has been the ability of the wage-earner to go to work each day. Just so soon as the wage-earners realize that they can have medical care as their due, without further expense than already borne by them, it is bound to increase enormously the demands on the medical profession. Of course, after a few years, when they become used to the idea, the mass of trivial and unnecessary calls will diminish, but a certain amount of unsuspected sickness among the poor will come to light and will probably increase the necessities of medical care beyond any calculated expectations. Adequate medical services to the patient

must contain, at times, the possibilities of more than the average practitioner can necessarily furnish. The standard demanded from the individual practitioner will probably not exceed that demanded under the English Act, which considers that adequate medical attention and treatment is that treatment of a kind which can consistently, with the best interests of the patient, be properly undertaken by a general practitioner of ordinary professional competence and skill. The physicians of the Book Printers' Sickness Fund, of Berlin, agree to care for all members not requiring hospital treatment and to expedite recovery to the best of their power. In the Leipzig Sickness Fund, physicians agree to give requisite treatment in accordance with the recognized custom of the medical profession. The English Act does no more than provide the advice of the panel doctor as to how further treatment may be obtained. It fails noticeably to furnish expert care or advice or adequate hospital accommodations; it only attempts to provide this in tuberculosis.

In the Sickness Societies of Germany there are many specialists to whom the patients may go. The Leipzig Society employed 130 specialists and 24 dental surgeons out of its total of 400 doctors; the Dresden Society 64 out of its total of 226. These necessary details of organization must be left to the arrangement of the local societies. There is no doubt, however, but that the details of what is ordinary and what is extra work, such as the difference between day calls and night calls, the difference between office visits and home visits, the detail of the ability of the general practitioner to call in a consultant if he or the patient shall demand it,

what shall be the fees under these circumstances, or whether all consultation work shall be done by the medical referees, are all questions coming up for decision.

There is no question that modern medical treatment demands more team work among physicians than was formerly done. The bacteriological examinations of sputum, of throat cultures, etc., are done in this country free of charge by the city and state departments of health. But X-ray diagnoses and any other special diagnostic procedures must still come under the specialist category.

This brings us to the question of the dispensaries, and back of the dispensaries, the hospitals. Up to this time the dispensaries and the hospitals have been the expression of the amount of free medical care that the city or state governments, or private corporations, were willing to give to the poor. A well conducted and well organized dispensary offers the most economical and efficient method of giving to the patients the many specialized medical services that the varying nature of their illnesses may require. More diversified medical and surgical work is performed in the dispensaries than is performed in the hospitals. There is less specialized service in the majority of the hospitals than in any dispensary of even moderate size. But there are more hospitals given over to special work than there are dispensaries so constituted, although most special hospitals have also a dispensary attached to them for the sake of obtaining patients to fill the hospitals. Most of the medical positions in dispensary or hospital are occupied without remuneration, the medical experience being sufficient compensation in this country for whatever time

or knowledge the doctor may bestow. Abroad, in certain countries, similar positions have a salary attached to them, and medical men are not expected to give their medical or surgical knowledge and services uncompensated.

Under the Sickness Insurance Law, the general dispensaries present opportunities for an adequate and well-developed method of furnishing abundant services in special branches of medical or surgical care to all patients who are not too sick for hospital care and who may require some special service which the average general practitioner cannot give them. The situation, however, will arise whether or not the dispensaries should be confined to the use of the development of the specialties and all the general medical care given in the homes of the patients, or whether patients shall be allowed to choose between their own doctor and some general practitioner in the dispensary as far as the general medical care is concerned. This is a question which contains serious possibility of dispute. It may be that the general medical classes of a dispensary may, in the end, be developed into a place where patients may go for expert diagnosis on the plane of the consultant, being referred back to their physician for care or being referred to specialists if such be necessary; the dispensary becoming then an institution for special care or expert diagnosis and not containing, as now, classes in ordinary internal medicine. However this may be decided, medical services rendered in the dispensary must, in future, receive remuneration, and free dispensaries soon be a thing of the past. Physicians in the dispensaries, moreover, must be under control of the com-

mittees controlling the doctors in general insurance practice, and if the dispensaries are run by private corporations, it must be within the power of the Commission to forbid persons under the Insurance Act to go to dispensaries which do not give adequate medical service. In all probability, if the Commission should publish to the insured that a certain dispensary was failing to give adequate medical care, the stigma of such publication would soon force any private corporation to give adequate medical services. The rules and regulations by which patients are permitted to accept the hospital provision of the Sickness Insurance Act will have to be under definite agreement and the care received in the hospitals under definite supervision.

Under the Workmen's Compensation Law, disputes arise because in the same ward one patient will be under the Compensation Law and another not, and any surgeon is liable to be accused by the patient not under the Compensation Law of neglecting him and favoring the man under Compensation, because of the extra fee given to the surgeon. The Workmen's Compensation Law makes certain poor patients pay-patients and necessarily leaves others out of this category. Sickness Insurance Laws will probably act in the same way in the medical wards in the same hospitals, and the human element of envy and resentment on the part of the patients will bring many disputes and complaints of the service rendered to them. It is doubtful if the attending physicians and surgeons in the large public hospitals should take positions on insurance panels. It would seem wiser if they did not. They usually have reached a position in their profession where their private practice is not among

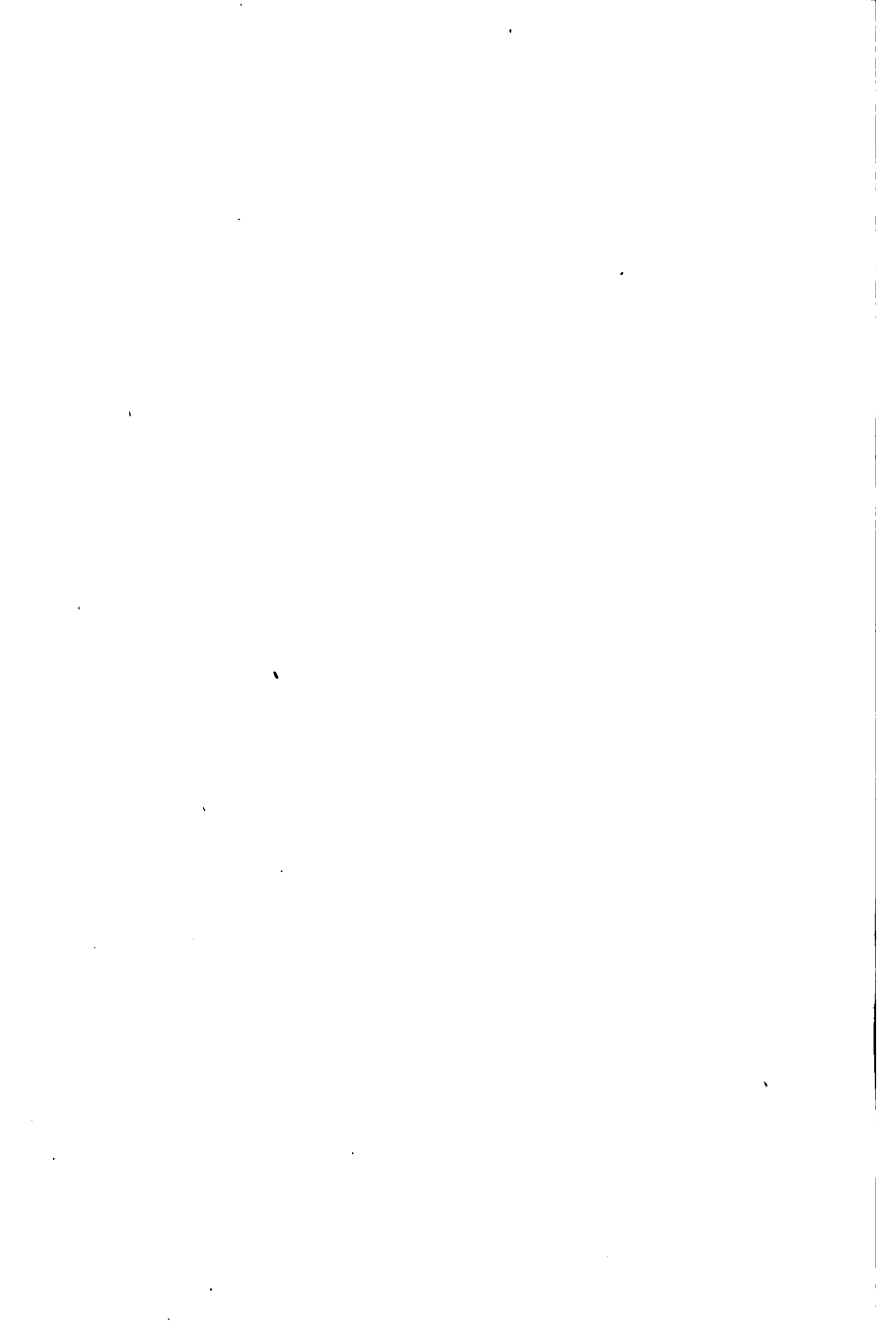
those persons who will be insured by the Sickness Insurance Act. It would seem wiser, therefore, that it should become a custom that the attending physicians, at least, should care for all alike without remuneration and that the special work required by the Sickness Insurance should be done by some assistant and not by the attending physician. The attending physician, therefore, in charge, would give his services to all alike and there could be no criticism or envy on the part of the patient for care received. The decision required by the Sickness Insurance Act as to when the patient was ready to leave the hospital and go to work, of filling out the certificate necessary under the working of the Act, the special daily hospital care and attention required, should be done by some assistant against whom the question of unequal attention between patients could not arise. Adequate supervision of smaller hospitals in which there is no house staff must be formulated by the Commission, for there is no question, as stated above, that adequate medical and surgical service must be given and must be controlled, whether this service be in the homes of the patients or in the hospitals and dispensaries to which they may go.

From the point of view of the insuring societies, they must realize that they must give to the medical profession an adequate remuneration for work done, and in return for a just fee they have a right to demand that the service given shall be of full time and medically adequate. The German method of giving generously a little more than the strict letter of the law demands in drugs, spectacles, trusses, and all medical and surgical apparatus, to the insured should be followed rather than the inade-

quate English method of giving only the cheapest medical and surgical appliances and refusing to give adequate spectacles or other surgical appliances because they are of more than average expense. The result in Germany has been a diminution of the length of time that medical benefits have been paid, and the result in England has been a long continuance of patients on the sick lists drawing money benefits. Judging from the Fabian report, the English method has been truly one of "penny wise, pound foolish."

We have considered here the working and necessities of medical care and control under a compulsory sickness insurance as exemplified chiefly in England and Germany, as these two types of compulsory insurance give the best examples of the results of the various methods employed for the carrying out of compulsory sickness insurance. Many difficulties of administration and many failures in administration have developed in both countries through the employment of the capitation plan of remuneration to the physicians. In Germany this has resulted in bitter animosity between the medical profession and the insuring societies and bitter contests for increased remuneration in which, in the enormous majority of contests, the physicians have won. In England it has resulted in inadequate care being given to the majority of the insured under the Act. In this country it would seem to be useless to attempt to repeat the inherent faults of capitation payment, and medical opinion and customs in this country are already in vigorous antagonism to this form of "contract practice." It would seem unwise, therefore, to start with the bitter antagonism of the medical profession against capitation.

This would seem to force the necessity in this country of a remuneration based on the visitation system. With this point of view clearly recognized, many difficulties experienced abroad will not occur and, in fact, the chief stumbling block to the successful carrying out of the law is removed.



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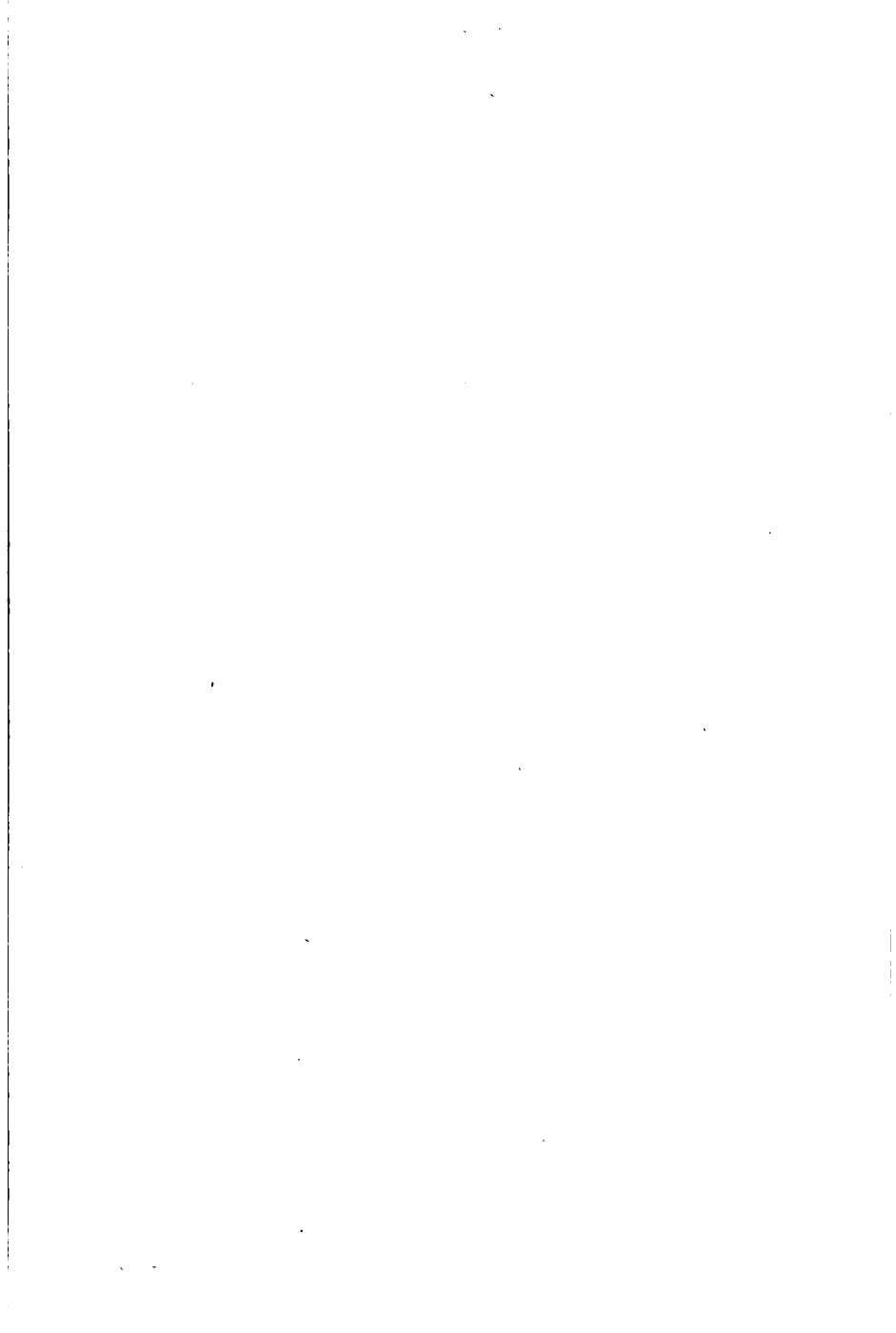
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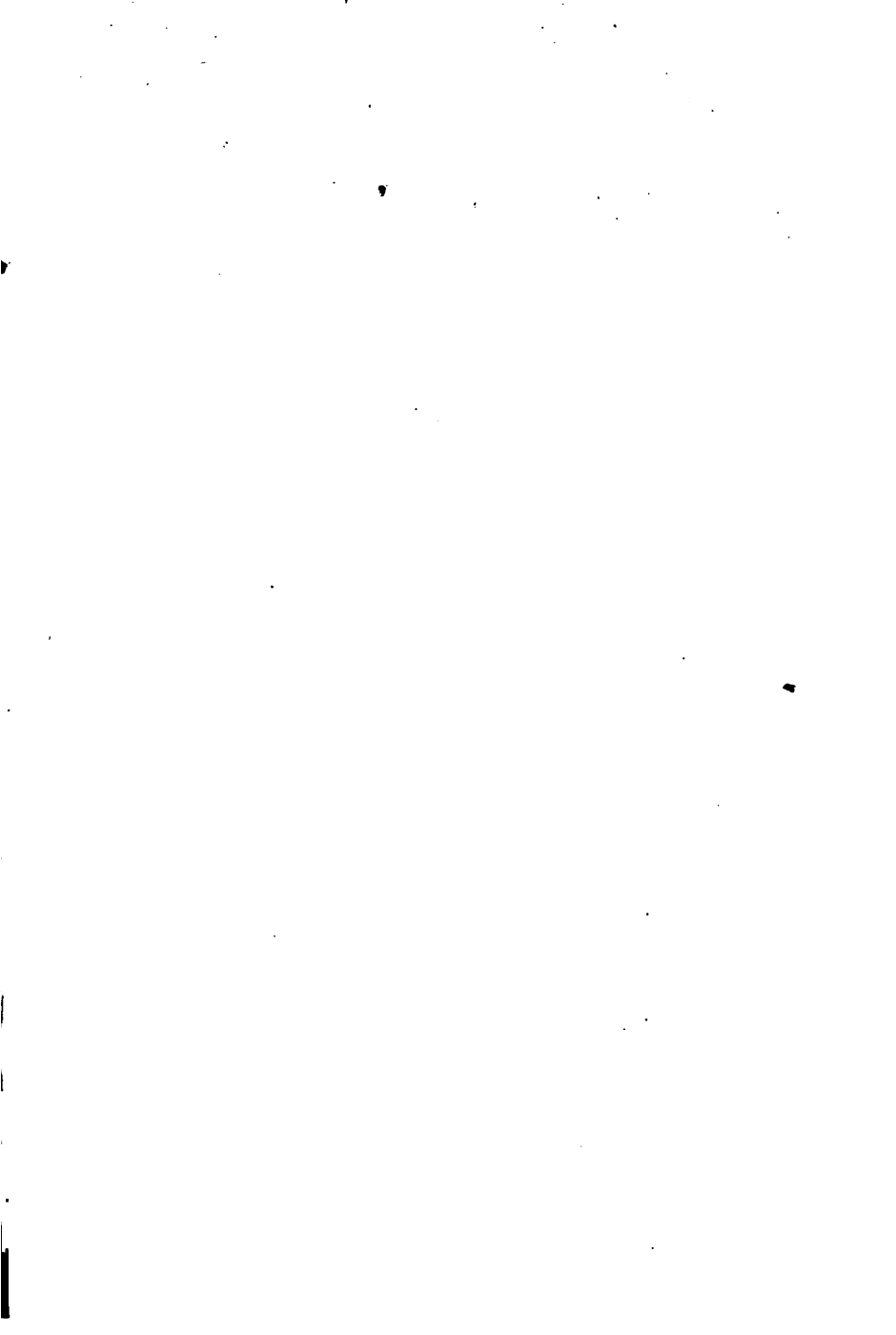
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